949 Kamokila Boulevard, 3rd floor, Suite 350
Kapolei, HI 96707

Health Services Referral Form

Please use this form to refer a member to the
Service Coordination / Disease Management Department

Please fax to 1-855-703-8078 or Call Customer Service at 1-888-846-4262

Member Information		
Name:	Phone #:	DOB:
'Ohana Member ID #:	Other Health Insurance & ID #:	
Caregiver / Contact Person:	Phone #:	

Referring Source Information		
Name of Referring Source:	Today's Date:	
Contact Name:	Phone #:	Fax #:

☐ Physician's Office ☐ Public Health Nurse ☐ Nurse Advice Line ☐ Member's Family/Caregiver
☐ Member ☐ Care Manager (Agency) _____ ☐ Other _____

Reason for Referral

☐ Member needs assistance with medication compliance & adherence to medical treatment plan
☐ Member needs coordination of care
☐ Member needs screening for home-based services
☐ Member needs assistance accessing Behavioral Health services
☐ Member inquiring about long-term care options
☐ Member may need Transplant / SHOTT referral
☐ Member needs health education in (check all that apply):
☐ Asthma ☐ COPD ☐ CAD ☐ CHF ☐ Hypertension
☐ Diabetes ☐ Smoking Cessation ☐ High Risk Pregnancy
☐ Member has social service needs:

Housing	*Basic Needs*	*Other*	*ICD-10 Z-Code(s)* *optional*
☐ Homeless	☐ Financial Assistance	☐ _____	_____ _____
☐ At-Risk for Eviction	☐ Food	☐ _____	_____ _____

Clinical Information / Other Information: *Include supporting clinical records, if necessary*

Other Pertinent Information

☐ Primary Diagnosis: _____
☐ Behavioral/Psychosocial barriers: _____
☐ Cognitive/ Physical deficits: _____
☐ Communication barriers: _____