



949 Kamokila Boulevard, 3<sup>rd</sup> 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

**Fax to 1-855-703-8078 or Call Customer Service @ 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 #:
<input type="checkbox"/> Physician's Office <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> Nurse Advice Line <input type="checkbox"/> Member's Family/Caregiver <input type="checkbox"/> Member <input type="checkbox"/> Care Manager (Agency) _____ <input type="checkbox"/> Other _____		
Reason for Referral		
<input type="checkbox"/> Member needs assistance with medication compliance & adherence to medical treatment plan <input type="checkbox"/> Member needs coordination of services <input type="checkbox"/> Member needs screening for home-based services <input type="checkbox"/> Member needs assistance accessing Behavioral Health services <input type="checkbox"/> Member inquiring about foster home or long-term care placement <input type="checkbox"/> Member needs health education in: <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> CAD <input type="checkbox"/> Depression <input type="checkbox"/> Other _____		
Clinical Information / Other Information: <i>Include supporting clinical records, if necessary</i>   		
Other Pertinent Information		
<input type="checkbox"/> Primary Diagnosis : <input type="checkbox"/> Behavioral/Psychosocial barriers: <input type="checkbox"/> Cognitive/ Physical deficits: <input type="checkbox"/> Communication barriers:		
Completed by 'Ohana Staff		
Referred to: <input type="checkbox"/> SC _____ <input type="checkbox"/> CCS _____ <input type="checkbox"/> CCM _____ <input type="checkbox"/> DM _____ Screened by: _____              Screening Date: _____		