



Service Coordination Referral Form

Fax to: 1-888-881-8220

Please print or type requested information below.

Mail available medical records to:
 Attn: Service Coordination and Disease Management
 Plaza at Milltown
 'Ohana Health Plan
 94-450 Mokuola St.
 Waipahu, HI 96797

Date:

Referral Date:

CHECK ONE OF THE FOLLOWING:	
Service Coordination <input type="checkbox"/>	Disease Management <input type="checkbox"/>
PATIENT INFORMATION	
Please verify with patients that all demographic information is correct for timely and effective processing.	
County	Member Phone #:
Member Name (Last, First, MI):	Member DOB:
Member Address (Full Address):	
Subscriber ID #:	
PCP Name:	PCP Phone Number:
Hospital Name:	Hospital Phone Number:

REFERRAL INFORMATION	
Name of Referring PCP or Specialist (Full Name):	
Phone Number: (Include Area Code)	Fax Number: (Include Area Code)
REASON FOR REFERRAL: (Include CLINICAL INFORMATION below)	

DIAGNOSIS: (Include CLINICAL INFORMATION below)	

SERVICE COORDINATION USE ONLY	
SC STATUS <input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	SC Screening Date:
Screened by:	Assigned to SC: Fill in if different from reviewer name
Reason for REJECTION:	