



Health Services Referral Form

Please use this form to refer a member to the Health 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 #:																	
<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 care <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 long-term care options <input type="checkbox"/> Member may need Transplant / SHOTT referral <input type="checkbox"/> Member needs health education in (check all that apply): <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> CAD <input type="checkbox"/> CHF <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> High Risk Pregnancy <input type="checkbox"/> Member has social service needs: <table border="0" style="width:100%"> <tr> <td style="text-align:center"><i>Housing</i></td> <td style="text-align:center"><i>Basic Needs</i></td> <td style="text-align:center"><i>Other</i></td> <td style="text-align:right"><i>ICD-10 Z-Code(s)</i></td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align:right"><small>*optional*</small></td> </tr> <tr> <td><input type="checkbox"/> Homeless</td> <td><input type="checkbox"/> Financial Assistance</td> <td><input type="checkbox"/> _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> At-Risk for Eviction</td> <td><input type="checkbox"/> Food</td> <td><input type="checkbox"/> _____</td> <td>_____</td> </tr> </table>				<i>Housing</i>	<i>Basic Needs</i>	<i>Other</i>	<i>ICD-10 Z-Code(s)</i>				<small>*optional*</small>	<input type="checkbox"/> Homeless	<input type="checkbox"/> Financial Assistance	<input type="checkbox"/> _____	_____	<input type="checkbox"/> At-Risk for Eviction	<input type="checkbox"/> Food	<input type="checkbox"/> _____	_____
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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: _____																			