Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1450
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

Referral Form

Reset Form

☐ Urgent

Provider Information		
Provider Name		Date of Referral
Patient Information		
First Name	Last Name	Date of Birth (MM/DD/YYYY)
Contact Person / Relationship	Phone Number / Mobile Number	*Patient's primary language (if not English)* ☐ The patient needs an interpreter

All of the below services are included with our program, kindly select the services you would like us to focus on with your patient.

- ☐ Patient Care Coordination (i.e. linking patients with resources in the community, helping to coordinate appointments)
- ☐ Patient Education (i.e. Treatment options, Advance Care Planning, Medications Management)
- ☐ Nutrition Services (CKD Nutrition education and counseling, meal planning, food label reading)
- ☐ Behavioral Health (Health coaching, Patient Engagement, BH Therapy, Counseling)
- ☐ Patient Outreach (i.e. contact to patients who are difficult to contact, who are missing appointments, etc.)
- ☐ Other (please describe):

***SPECIFY PATIENT'S NEEDS:**

- ☐ Demographics and Clinical Profile
- ☐ Last Progress Note with Medication List
- ☐ Nephrology Consult Note and/or Discharge Summary
- ☐ Renal imaging results if available (US/CT)
- ☐ Labs (please include 2 years of eGFR and serum creatinine values, if available)

Referring provider's preferred mode of communication/feedback: ☐ Fax ☐ Elation