

REFERRAL FORM

Preferred mode of communication/feedback: Fax Elation Urgent

Provider Information

Physician Name		Date
Office Contact Person	Phone Number	Fax Number

Patient Demographic Information

Patient Name	DOB	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> T
Primary Contact Name / Relationship to patient	Primary Contact Phone	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Mailing Address (Street, City, State, Zip)		
Language(s) Spoken		Need Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No

Insurance Information

Insurance Carrier:

<input type="checkbox"/> HMSA PPO	<input type="checkbox"/> HMSA Akamai Advantage	<input type="checkbox"/> UHA	<input type="checkbox"/> Medicare – Humana PPO	<input type="checkbox"/> Other: _____
<input type="checkbox"/> HMSA HMO	<input type="checkbox"/> UnitedHealthcare	<input type="checkbox"/> HMAA	<input type="checkbox"/> Medicare – Humana HMO	
<input type="checkbox"/> HMSA QUEST	<input type="checkbox"/> AlohaCare	<input type="checkbox"/> Ohana	<input type="checkbox"/> Medicare – UnitedHealthcare	

Member ID: _____

PCP (if different from above): _____

Referral Reasons

- Care Coordination** (i.e. patient outreach, connecting patients with resources in the community, scheduling appointments)
- Chronic Conditions Education** (i.e. DM/HTN education, treatment options, advance care planning, medication adherence)
- Nutrition Services** (CKD Nutrition education and counseling, meal planning, food label reading)
- Behavioral Health** (Health coaching, Patient Engagement, BH Therapy, Counseling)
- Other:** _____

Current CKD Stage (3a – 5): Stage 3a Stage 3b Stage 4 Stage 5

Patient has a Nephrologist <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Nephrologist Name
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Please include the documents listed below when sending the referral:

- | | |
|--|---|
| <input type="checkbox"/> Demographics, ID/Insurance Card, and Clinical Profile | <input type="checkbox"/> Medication List |
| <input type="checkbox"/> PCP Consult Note and/or Discharge Summary | <input type="checkbox"/> Last Progress Note with Medication List |
| <input type="checkbox"/> Labs (include most recent eGFR and serum creatinine values) | <input type="checkbox"/> Renal imaging results if available (US/CT) |

Addition Comments: (Provider's Request or Recommendations)	Provider's Signature
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Fax completed form to Mālama Kidney Center (MKC) at **(808) 913-3843**