# Hui Mālama Ola Nā ʻŌiwi

*Hawaiʻi Island Health Care System*

# REFERRAL FORM

**DATE:** ___________________

**NAME:** *(Last, First, Middle Initial)* ____________________________________________________________

**Phone No:** ______________**Date of Birth:**___________________**Age:** ______ **Sex:** ( )**Male** ( )**Female**

**Resident Address:** ___________________________________________________________________________

**Mailing Address:** ____________________________________________________________________________

**Health Insurance Carrier:** ____________________**Coverage Type:** ☐**HMO** ☐**PPO Member ID #** ______________

**Referred To:** *(Please check one of the following Hui Mālama Ola Nā `Ōiwi offices)*
( ) Hilo Office: Phone: 969-9220, Fax: 961-4794
( ) HMONO Family Medicine Clinic: Phone: 796-3125, Fax: 796-3128
( ) Other *(Name, Address, Phone No.)*: ___________________________________________________

**Services Being Referred To:**

☐Behavioral Health Services
☐Cancer Support Group
☐Diabetes Program/Education-Group
☐Diabetes Program/Education-Individual
☐**Diabetes Support Group**
☐Exercise and Fitness Program
☐Healthy Hapai

☐Health Resource Services
☐Hypertension Program/Education
☐Medical Services
☐Nutrition Education-Group
☐Nutrition Education-Individual
☐Specialty Transportation

**Traditional Health Services**
☐Grow your own garden Lāʻau
☐Hoʻoponopono
☐Lāʻau Lapaʻau
☐Lomilomi

**Referred From:** *(Name, Address, Phone No.)* ______________________________________________________

Physician/Clinic: ___________________________________________________ Phone: __________________

Diagnosis/ICD-10:_____________________________________________________________________________

Reason for Referral: __________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

*I hereby certify that I am managing this beneficiary's health condition and that the above prescribed training is a necessary part of management.*

**Physician Signature:** ____________________________________________ **Date:** ______________________

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*All of the above have been discussed and reviewed with me and I agree to be referred to the service(s) as recommended.*

**Client Signature:** ____________________________________________________ **Date:** ______________________

HMONO Staff Signature: _________________________________ Received Date: ______________________

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• 1438 Kilauea Avenue Hilo, Hawaiʻi 96720 • **Phone:** (808) 969-9220 • **Fax:** (808) 961-4794
•73 Puuhonu Place, Suite 101 Hilo, Hawaiʻi 96720 • **Phone:** (808) 796-3125 • **Fax:** (808) 796-3128
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