Kāpili Kōkua Care Coordination

PEDIATRIC REFERRAL FORM

Fax completed form to Integrated Health Hawaii (IHH) at (808) 930-9874)

Provider Information

Physician Name		Date
Office Contact Person	Phone	Fax

Demographic Information

Patient Name	DOB	Gender ☐ M ☐ F ☐ T

Primary Insurer

☐ HMSA (choose LOB) ☐ UHA ☐ Ohana ☐ Tricare
☐ HMO ☐ PPO ☐ QUEST ☐ United Health Care ☐ Aetna ☐ HMAA
☐ Akamai Advantage ☐ Other: ☐ Aloha Care ☐ Other:

Primary Contact Name	Primary Contact Phone	☐ Home ☐ Cell ☐ Work

Relationship to Patient

☐ Self/Patient ☐ Parent ☐ Sibling ☐ Grandparent ☐ Stepparent
☐ Foster-parent ☐ Legal Guardian ☐ Friend ☐ Other:

Mailing Address (Street, City, State, Zip)

Language(s) Spoken	Need Interpreter ☐ Yes ☐ No

Referral Information

☐ CSHCN ☐ Behavioral Health ☐ Other:

Presenting Problem

Pertinent Medical History

Objectives (*What do you want the care coordinator to accomplish?)*

Provider Signature

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pmaghawaii.org/pqh

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