Specialty Referral Form for Hawai'i's CSHCN

Patient Information

Patient Name: _____ DOB: _____ Gender: M ☐ F ☐

Parent/Caregiver Name: _____ Phone: _____

Language Spoken at Home: (if other than English) _____ Translator or Interpreter Needed? ☐ Yes ☐ No

Patient's Current Dx: (related or unrelated to referral) _____

PCP: (if different than Ref. MD) _____

Request: ☐ *Referral* ☐ *Consult*

☐ Cardio ☐ Dev/Beh ☐ Gastro ☐ Neuro ☐ Pulmo ☐ Rheum ☐ Other

Referral Reason: _____

_____

_____

_____

Referral To: _____

Referral From: _____

Address: _____

Phone/Fax: _____

Best Way and Time to Contact: _____

Background Information

Pertinent Data

☐ Lab	☐ Fax	☐ Attached	☐ Sent w/patient	☐ Mailed	☐ Online at	
☐ Radiology	☐ Fax	☐ Attached	☐ Sent w/patient	☐ Mailed	☐ Online at	
☐ Imaging	☐ Fax	☐ Attached	☐ Sent w/patient	☐ Mailed	☐ Online at	
☐ Growth Charts	☐ Fax	☐ Attached	☐ Sent w/patient	☐ Mailed	☐ Online at	
☐ Head Circumference	☐ Fax	☐ Attached	☐ Sent w/patient	☐ Mailed	☐ Online at	

☐ Treatment Initiated Type: _____

Treatment Response: _____

_____

Insurance Data

Government: ☐ Medicaid ☐ TriCare QUEST: ☐ HMSA ☐ AlohaCare ☐ Kaiser

Commercial: ☐ HMAA ☐ HMSA ☐ Kaiser ☐ MDX ☐ Summerlin ☐ UHA ☐ Workers' Union

☐ Other Type: _____ Prior Auth/Referral Initiated? ☐ Yes ☐ No