Nā Pu'uwai
Native Hawaiian Health Care System
The Wellsprings of Life

Service Referral Form

To expedite processing, referrals can be sent via:
Fax: (808) 560-3385
Mail: P.O. Box 130, Kaunakakai, Hawaii 96748

Date: _____ Sex: ☐ Male ☐ Female

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ _____ _____
P.O. Box or Street City Zip Code

Contact Information: _____ _____ _____
Home Mobile Email

Does the patient have health insurance? ☐ Yes (complete insurance information below) ☐ No

Primary Insurance Plan

Insurance Plan: ☐ HMSA ☐ Alohacare ☐ Ohana ☐ United Health Care ☐ VA ☐ Other: _____

Subscriber ID: _____ *Subscriber Name: _____ *DOB: _____
*If other than referred patient

This patient/client is being referred to Nā Pu'uwai Integrative Health Center for (select all that apply):

Primary Care Services:
☐ Establish Primary Care

Behavioral Health Services:
☐ Individual Counseling-Adult
☐ Individual Counseling-Child
☐ Couples Counseling
☐ Substance Use Treatment
☐ Tobacco Cessation

Specialty Services:
☐ Kāwili Clinic (Dr. Opunui)

Nutrition Services:
☐ Nutritional Counseling-Adult
☐ Nutritional Counseling-Child

Kūpuna Care Services:
☐ Adult Day Care
☐ Home Care

Gym:
☐ Integrative Fitness Center

Special Accommodations:
☐ Sign Language/Interpreter Services ☐ Wheelchair/Walker ☐ Other: _____

ALL REFERRALS MUST INCLUDE DOCUMENTATION OF THE NEED INCLUDING MEDICAL NOTES FROM AN OFFICE VISIT AS WELL AS LABWORK AND/OR NECESSARY TESTING FOR DIAGNOSIS.

_____ _____
Name of Referring Provider Signature of Referring Provider

Referring Office and/or Clinic:
☐ Dr. Daniel S. McGuire, MD
☐ Ka Hoailona Rural Health Clinic
☐ Molokai Community Health Center
☐ Molokai Family Health Center
☐ Molokai General Hospital
☐ Lanai Community Health Center
☐ Other: _____
☐ Straub Medical Center-Lanai
☐ Molokai General Hospital-Outpatient Clinic