Programs 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 Zipcode

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 Na Pu'uwai Integrative Health Center for (select all that apply):

☐ **Haku'ala Chronic Kidney Disease Program July 2023 (Complimentary Pilot Program)**

PLEASE INCLUDE:

- **Indicate chronic kidney disease stage diagnosed**
- **Most recent consult note.**
- **List of Comorbidities**
- **Most recent labs:**
  - **Renal profile with Glomerular Filtration Rate (eGFR)**
  - **Urine Albumin Creatinine Ratio (uACR)**
  - **Any other recent lab results available.**

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:

☐ Molokai Community Health Center ☐ Molokai General Hospital Outpatient Clinic ☐ Liberty Dialysis
☐ Lanai Community Health Center ☐ Lanai Community Hospital ☐ Other: _____