***NON-HMSA PATIENTS: FAX DIRECTLY TO PQH AT (808) 943-8732***

***HMSA PATIENTS: FAX TO HMSA AT (808) 948-8242***

**CARE Referral Form**

|  |  |  |
| --- | --- | --- |
| **Provider Information** | | |
| Provider Name | | Date |
| Office Point of Contact | Phone Number | Fax Number |
| **Patient Information** | | |
| First Name | Last Name | Date Of Birth (MM/DD/YYYY) |
| Phone Number / Mobile Number | Mailing Address | ***POA: If applicable, also fax a copy of the Authorized Representative document.*** |
| HMSA Line of Business (LOB)  Commercial QUEST (ID# ) Akamai Advantage  Medicare FFS Non-HMSA (Insurer: ) | | Language Spoken In Household  Interpreter Needed: Yes No |
| **Service Requested** | | |
| Complex Case Management Behavioral Health Disease Management  Health Coaching (🔿 Physical Activity / 🔿 Nutrition / 🔿 Tobacco Cessation/ 🔿 Stress Mgmt / 🔿 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  Patient notified about and agreeable to care management referral. | | |
| **\*REQUIRED: Primary Care Provider’s PRIMARY Concern**  **(PLease include pertinent meds and progress notes)** | | |
|  | | |

**PATIENT PLAN OF CARE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Care Manager / Health Coach Information** | | | | | |
| Name | Phone Number | Fax Number | | Date | Initial  Follow-up |
| **Problem(s) And Goal(s):** | | | | | |
|  | | | | | |
| **Patient Progress:** | | | | | |
|  | | | | | |
| **Action Taken:** | | | | | |
|  | | | | | |
| **Recommendation And Follow-Up** | | | | | |
| HMSA Clinician’s Request And Recommendation: | | | Provider’s Response And Recommendation: | | |