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

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

**CARE Referral Form**

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| **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)** |
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**PATIENT PLAN OF CARE**

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| **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:  |