I OLA LĀHUI
BEHAVIORAL HEALTH REFERRAL FORM

Date: _____ **( ) Initial** **( ) Follow Up**

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip Code: _____

Preferred Contact Number: Mobile _____; Other _____

Insurance Information

Primary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber #: _____ Group #: _____

Clinical Information

Referral Source: □ PCP □ Ins. Carrier □ Website □ Word of Mouth □ Other

Referral Details:

_____

Reason for Referral:

Behavioral Health		Chronic Disease Management	Lifestyle Management
□ Mood Disorder	□ Anxiety	□ Diabetes	□ Sleep Disturbance
□ Adjustment	□ Psychosis	□ Hypertension	□ Weight Management
□ Substance Abuse	□ Trauma	□ Chronic Pain	□ Stress Management
		□ Headaches: Tension, Migraine	□ Tobacco Cessation

Any Specific Questions or Requests: _____

_____

Preferred Appointment (Day/Times): _____

APPOINTMENT DATE: _____

ASSIGNED PROVIDER: _____