PMAG
Pacific Medical Administrative Group
Services provided by PQH

Integrated Health Hawaii

IHH Care Coordination

REFERRAL FORM

Fax completed form to Integrated Health Hawaii (IHH) at (808) 930-9874

Provider Information		
Physician Name		Date
Physician Specialty: ☐ Adult ☐ Pediatrician ☐ Family		
Office Contact Person	Phone Number	Fax Number

Patient Demographic Information		
Patient Name	DOB	Gender ☐ M ■ F ☐ T
Primary Contact Name	Primary Contact Phone	☐ Home ☐ Cell ☐ Work

Relationship to Patient

☐ Self/Patient ☐ Parent ☐ Sibling ☐ Grandparent ☐ Daughter/Son
☐ Spouse ☐ Legal Guardian ☐ Friend ☐ Foster-parent ☐ Other:

Mailing Address (Street, City, State, Zip)

Language(s) Spoken	Need Interpreter ☐ Yes ■ No

Pacific Health Care (PHC) Subscriber Number:

Referral Reasons

☐ **Medical:** Coordination of care (specialist and other providers)
☐ **Behavior health:** coordination for evaluation, dx, referral to mental health provider.
☐ **Developmental delay:** referral to state agency (DOE, DDD) and other community resources.
☐ **Family:** referral to family counseling, SDOH (housing, food, state/fed programs)
☐ **Geriatric/caregiver support:** evaluation for referrals and services.
☐ **Social determinants of health:** transportation, housing, food, state/fed programs.

Addition Comments: *(Brief Description or Recommendations for referral)*

Non – PHC

HMSA Line of Business (LOB)		**Non-HMSA Insurance**		
☐ Commercial	☐ QUEST	☐ UHA	☐ Ohana	☐ Tricare
☐ Medicare FFS	☐ Akamai Advantage	☐ UHC	☐ AlohaCare	☐ Other:
☐ HMO (Not PHC)	☐ Other:	☐ HMAA	☐ Aetna	

Diagnosis or clinical presentation of: ***(Required for Non-PHC patients 18+)***

Provider's Request and Recommendation:	**Provider's Signature**

NOTES: (1) Send follow-up reports if there are significant changes (2) For more information and detailed report, contact the IHH care coordinator.