Mālama KIDNEY CENTER

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Honolulu, HI 96814
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REFERRAL FORM

Preferred mode of communication/feedback: ☐ Fax ☐ Elation ☐ Urgent

Provider Information		
Physician Name		Date
Office Contact Person	Phone Number	Fax Number
Patient Demographic Information		
Patient Name	DOB	Gender ☐ M ☐ F ☐ T
Primary Contact Name / Relationship to patient	Primary Contact Phone	☐ Home ☐ Cell ☐ Work
Mailing Address (Street, City, State, Zip)		
Language(s) Spoken		Need Interpreter ☐ Yes ☐ No

Insurance Information

Insurance Carrier:

☐ HMSA PPO	☐ HMSA Akamai Advantage	☐ UHA	☐ Medicare – Humana PPO	☐ Other:
☐ HMSA HMO	☐ UnitedHealthcare	☐ HMAA	☐ Medicare – Humana HMO	_____
☐ HMSA QUEST	☐ AlohaCare	☐ Ohana	☐ Medicare – UnitedHealthcare	

Member ID:

PCP *(if different from above)*:

Referral Reasons

☐ **Care Coordination** (i.e. patient outreach, connecting patients with resources in the community, scheduling appointments)
☐ **Chronic Conditions Education** (i.e. DM/HTN education, treatment options, advance care planning, medication adherence)
☐ **Nutrition Services** (CKD Nutrition education and counseling, meal planning, food label reading)
☐ **Behavioral Health** (Health coaching, Patient Engagement, BH Therapy, Counseling)
☐ **Other:**

Current CKD Stage (3a – 5): ☐ Stage 3a ☐ Stage 3b ☐ Stage 4 ☐ Stage 5

Patient has a Nephrologist ☐ Yes ☐ No	If Yes, Nephrologist Name

Please include the documents listed below when sending the referral:

☐ Demographics, ID/Insurance Card, and Clinical Profile
☐ PCP Consult Note and/or Discharge Summary
☐ Labs (include most recent eGFR and serum creatinine values)
☐ Medication List
☐ Last Progress Note with Medication List
☐ Renal imaging results if available (US/CT)

Addition Comments: *(Provider's Request or Recommendations)*	**Provider's Signature**

Fax completed form to Mālama Kidney Center (MKC) at (808) 913-3843