

FAX TO (808) 792-8441 (O'ahu)/1-833-711-1663 (Neighbor Islands)
 (808) 792-8402 (O'ahu)/1-877-544-0777 (Neighbor Islands)

This form is for Referral to MDX Hawai'i's Medical Management Department. *Please complete all fields on both pages and fax this form to MDX Hawai'i.* Please include any relevant medical records with this form.

SUBMITTED DATE		REFERRING PROVIDER NAME	
PHONE		CONTACT PERSON	
MEMBER INFORMATION			
MEMBER NAME: (LAST, FIRST M.I.)			
MEMBER ID	DOB	PHONE	
PROVIDER INFORMATION (if applicable)			
PRIMARY CARE PHYSICIAN	PHONE	FAX	
SPECIALTY PHYSICIAN	PHONE	FAX	
BEHAVIORAL HEALTH PHYSICIAN	PHONE	FAX	
REASON FOR REFERRAL TO CARE COORDINATION (check "✓" all that apply)			
SERVICE COORDINATION	CARE COORDINATION & COMPLEX CASE MANAGEMENT	ALA 'O HO'OLA (*High risk patients who require home or telehealth visits by APRN)	
<input type="checkbox"/> Health Plan Benefits assist member to understand and access benefits	<input type="checkbox"/> CKD Self-Management <ul style="list-style-type: none"> condition education medication education Advanced Care Planning 	<input type="checkbox"/> Complex Chronic Condition Assessment for High-Risk Patients <ul style="list-style-type: none"> recommendations for complex plan of care 	
<input type="checkbox"/> Mom's Meals Benefit meals provided after discharge from SNF or hospital (if member meets benefit criteria)	<input type="checkbox"/> ESRD <ul style="list-style-type: none"> condition education optimal starts fluid overload 	<input type="checkbox"/> Two or More Inpatient Admissions within last year or Two or More ER Visits within last 6 months	
<input type="checkbox"/> Medication Copays provide possible resources to assist with cost of medications	<input type="checkbox"/> Heart Disease Self-Management <ul style="list-style-type: none"> condition education medication education Advanced Care Planning 	<input type="checkbox"/> Medication Reconciliation and/or coordination <ul style="list-style-type: none"> Education provided on medications 	
<input type="checkbox"/> Transportation provide possible resources for transportation to medical appointments	<input type="checkbox"/> Diabetes Self-Management <ul style="list-style-type: none"> condition education medication education Advanced Care Planning 	<input type="checkbox"/> Advance Care Planning Education provided on <ul style="list-style-type: none"> Advanced Directives POLST 	
<input type="checkbox"/> Food Insecurity provide possible resources if member facing food insecurity	<input type="checkbox"/> Two or More Inpatient Admissions within last year <ul style="list-style-type: none"> Chronic Kidney Disease Heart Disease 	<input type="checkbox"/> Education & Training <ul style="list-style-type: none"> pathophysiology and management of chronic diseases >blood pressure >glucometer and blood sugar measurement >monitoring daily weight >diet education 	
<input type="checkbox"/> Community Resources assist member to understand & access available resources	<input type="checkbox"/> Two or More ER Visits within last 6 months <ul style="list-style-type: none"> Chronic Kidney Disease Heart Disease 		
<input type="checkbox"/> Behavioral Health – Assistance with finding a Behavioral Health Provider or Services			

COVID 19 Vaccination Status

- Vaccinated and boosted
- Vaccinated, but not boosted
- Not vaccinated

Important information for the case manager (eg. best time to call, special needs such as hearing impairment, speaks language other than English-please identify language, etc.) _____

Please explain any resources or interventions that have already been provided _____

- No resources nor interventions have been provided

Please explain your goals for this intervention and specific desired outcomes _____

Please confirm the following

- My patient is aware that I referred him/her to case management
- I have attached recent clinical notes, pertinent labs and tests, and the current medication list
- If my patient is unable to engage with the case management team, I have attached a POA