I OLA LĀHUI
BEHAVIORAL HEALTH REFERRAL FORM

1441 Kapi‘olani Blvd. Ste. 1802 ~ Phone: (808) 525-6255 ~ Fax: (808) 525-6256

Date: _____

Patient Information

Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip Code: _____

Email: _____

Preferred Contact Number: Mobile _____; Other _____

Insurance Information

Primary Insurance Company: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber #: _____ Group #: _____

Clinical Information

Referring Physician/Provider:_____ Telephone: _____

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
□ Behavior Concerns □ Couples	□ Headaches: Tension, Migraine	□ Tobacco Cessation
□ Parenting or Family	□ Epilepsy	□ Other: _____
□ Aging Issues or Caregiving	□ Other: _____	
□ Other:_____		

Any Specific Questions or Requests: _____

Location (Circle One): In Person Telehealth Combined No Preference

Preferred Appointment (Day/Times):_____

Please fax completed referral form to I Ola Lāhui at **(808)525-6256**.
Call us at (808)525-6255 with questions. Mahalo!

For IOL office use only:

Provider:_____ Appointment Date: _____