Kālele Care Services Referral Form

Fax to: 808-865-5982 | Phone: 808-871-9215

Fax this completed Referral Form along with the Patient Demographics and Most Recent Provider Note

REFERRAL SOURCE INFORMATION	
Date of Referral	Referring Provider
Organization	Contact Person and Info
PATIENT INFORMATION (May be left blank if included in the Face Sheet)	
Name	DOB
Address	Phone
Insurance Plan and Number	Primary Care Provider

REASON FOR REFERRAL TO KALELE (Select all that apply)

☐ Post-Discharge Follow-Up/Transition of Care Support

☐ Interim Medical Support for Homebound Patients (e.g., Home Health Care Oversight)

☐ Health Care Access and System Navigation

☐ Social Services Navigation (e.g., transportation, food, housing, caregiver support)

☐ Health Education and Facilitating Behavioral Changes

☐ Facilitating Social and Emotional Support

☐ Assessment for Palliative Care

Additional Notes:

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Thank you for partnering with Kālele to support our kūpuna