QUEEN'S CLINICALLY INTEGRATED PHYSICIAN NETWORK

Ulana Ke Ola
To Weave Health

QCIPN Clinical Care Coordination and Advance Care Planning Clinic Referral Form

PATIENT'S INFORMATION	
Referral Date:	
Patient's Name:	**Date of Birth:**
Patient's Phone#:	
Address:	
Special needs (i.e. sensory impaired, needs an interpreter, dementia):	
Is Patient/Family aware of this referral?	
Responsible Person/Health POA & Contact Info:	
Medicare ID#:	**HMSA Member# (if applicable):**
REFERRAL INFORMATION	
Referral Source:	
Phone #:	**Fax #:**
Primary Care Provider (if different than referral source):	
Phone #:	**Fax #:**
Reason(s) for Referral (check all boxes that apply): ❑ **Clinical Care Coordination, Behavioral/Mental Health** **Please attach pertinent info (e.g., H&P, most recent visit note, PHQ-9)* ❑ **Advance Care Planning Clinic** (Advance Health Care Directives/Provider Order of Life Sustaining Treatment or POLST form) **Please have patient/family bring AHCD and/or POLST if available to ACP Clinic*	
Reason(s) for Referral/Comments:	

Questions? Please contact the team directly at: **Phone: 808-691-7735**

Mon to Fri, 8:00am to 4:30pm
(Office closed on Queen's observed holidays)

Fax the completed referral form to: **Fax: 808-691-4053**