REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS EMOTIONAL DISTURBANCE (SED)

Med-QUEST Division - Phone: 692-8127 Fax: 692-8131

NAME: _____, _____ ☐ Male ☐Female
Last *First* *MI*

HOME ADDRESS: _____ Phone No. _____

_____ Case No. _____

MAILING ADDRESS: _____ Client ID No. _____

_____ SSN: __ __ __ / __ __ / __ __ __ __

DOB: __ __ / __ __ / __ __ Age: _____ COUNTY: ☐ Oahu ☐ Hawaii ☐ Maui ☐ Kauai

HEALTH PLAN: ☐ AlohaCare ☐ HMSA ☐ Kapiolani ☐ Kaiser ☐ Queens ☐ Straub ☐ Medicaid ☐ Medicaid/Medicare

DATE OF REFERRAL: __ __ / __ __ / __ __

PRIMARY DIAGNOSIS: _____ DSMIV CODE __ __ __.__ __

SECONDARY DIAGNOSIS: _____ DSMIIV CODE __ __ __.__ __

CURRENT MEDICAL CONDITIONS (Indicate, if none) _____

_____. NAME OF PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT: ☐Castle ☐ Queen's ☐ _____ Admitted on ___/___/___**			
PAST HOSPITALIZATIONS:				
Facility	*Location*	*Date Admitted*	*Date Discharged*	*Diagnoses*

NAME OF MEDICATION	STRENGTH	DOSAGE	START DATE	END DATE

OUTPATIENT TREATMENT		DATES	
THERAPIST	DIAGNOSES	From	To

Section below to be completed by Evaluation Panel

Date of Evaluation: __ __/__ __/__ __ Date of Report __ __/__ __/__ __ Date of Enrollment/Disenrollment __ __/__ __/__ __

SMI: ☐ Yes ☐ No ☐ Additional Information Needed: _____

SED: ☐ Yes ☐ No _____

Reason for denial/comments: _____

_____

Revised 5/2001