The Institute for Human Services
Ending The Cycle of Homelessness

Kaaahi Women/Family Shelter
546 Kaaahi Street
Honolulu, HI 96817
Ph (808)-845-7052
Fax (808) 845-7357

Sumner Men's Shelter
350 Sumner Street
Honolulu HI 96817
Ph (808) 537-2724
Fax (808) 537-2697

IHS Hospital REFERRAL FORM

The purpose of the IHS Hospital Referral Form is to ensure that individuals being referred to IHS are appropriately accommodated and will receive proper attention and follow-up upon arrival. Organizations should not attempt to send individuals to IHS until the referral form has been approved.

Referral Organization: _____ **Individual Being Referred:** _____

Address: _____ **SSN:** _____ **DOB:** _____

Contact Person: _____ **Height/Weight:** ____**ft.** ____ **in.** ____ **lbs.**

Phone: _____ **Fax:** _____ ☐ **Male** ☐ **Female** ☐ **Transgender**

Reason for Hospital/Care Admission: _____
Diagnosis (es): _____
Physician: _____ **Physician Contact Number**: _____
Medications: _____

Mental Health/ Chemical Dependency Status:

1. Current Mental Status: ☐Alert ☐Oriented to time/place ☐ Memory loss: ☐Short-term ☐Long-term ☐Both
2. Mental Health History: _____
3. History of violent behavior? ☐YES ☐NO _____
4. Compliant with medication? ☐YES ☐NO ☐N/A
5. History of substance abuse/chemical dependency?
   ☐YES ☐NO If yes, list substance(s): _____
6. Drug Screen Results? ☐ Pos. for _____ ☐ Neg
7. Length of current hospital stay? _____
8. Length of time in state of Hawaii? _____
9. History of suicidal behavior? ☐YES ☐NO _____
10. Reason/ dates of last admit(s)? _____
    _____
11. AMHD eligible? ☐YES ☐NO
    CM Name: _____
    Contact #: _____
12. Income (source & amount): _____

Ability to Perform Activities of Daily Living (ADL's) without assistance:

- ✓ Walk at least 30 feet? ☐YES ☐NO
- ✓ Ambulatory aides (wheelchair/walker)? ☐YES ☐NO
  If yes, able to transfer independently? ☐YES ☐NO
- ✓ Get in/out of bathroom stall w/o assist? ☐YES ☐NO
- ✓ Feeds self? ☐YES ☐NO
- ✓ Toilet self? ☐YES ☐NO
- ✓ Bathe self? ☐YES ☐NO
- ✓ Maintain good hygiene? ☐YES ☐NO
- ✓ Ability to communicate w/ English? ☐YES ☐NO If no, what language? _____

Medical Condition:

1. Positive PPD? ☐YES ☐NO Date done: _____ Date Read: _____ Chest X-ray date: _____ Results: Pos. / Neg.
2. Stable. Does not require follow-up? ☐YES ☐NO
3. Can self-administer & monitor own meds? ☐YES ☐NO
4. Adherent to all aspects of medical care? ☐YES ☐NO
   If no, please explain: _____
5. Intact immune system? ☐YES ☐NO
6. History of known communicable disease? ☐YES ☐NO
   If yes, list: _____
7. Other external appliances? ☐YES ☐NO
   If yes, able to manage independently? ☐YES ☐NO
8. Special diet requirements? _____

Other Comments:

_____

_____

FOR IHS USE ONLY
Status of Referral:
☐ Approved with stipulations _____
☐ Need for Information, please call _____ at _____
☐ Denied Reason(s): ☐ Shelter at full capacity ☐ Individual is suspended from IHS
☐ Other: _____
IHS Signature: _____ Date: _____ Time: _____
IHS Staff (printed name): _____ Position: _____