Department of Public Health and Social Services
Division of Public Welfare
Bureau of Health Care Financing

OFF-ISLAND CARE REFERRAL FORM

Patient's Full Name	DOB	Case No.	Hospital No.

Current Address	Telephone No.	Third Party Coverage	☐YES	☐NO
		☐Medicare	☐SelectCare	☐Pacificare
		☐Staywell	☐Multicover	☐Other_____

Detailed Description Of Patient's Health Problems:

Purpose For Sending Patient Off-Island:

Accepting Facility:

Contact was made on:_____

Accepting Physician:

Contact was made on:_____

Date of Departure: Appointment Date:

Approximate Date of Return:

Patient's Certification: I authorize any holder of medical or other information about me concerning my illness or treatment to be released to the Department of Public Health and Social Services or its authorized representatives.

_____ _____
Signature (Patient or Authorized Representative) Date

Attending Physician Signature:

Date:

Action	Consultant Physicians Signature:
☐ Approved ☐ Disapproved Reason:_____ _____ _____	Date:

NOTE: Please attach necessary Medical Summary and all pertinent findings for medical review.