THE QUEEN'S MEDICAL CENTER
KAHI MOHALA

REFERRALS
Hours: Mon-Fri, 8am-4pm
Phone: (808) 686-5250 - Fax: (808) 686-5239
Email: KMReferrals@queens.org

CHILD/ADOLESCENT RESIDENTIAL PROGRAM APPLICATION

Thank you for trusting The Queen's Medical Center – Kahi Mohala. Please complete this application and send the following information:

- ☐ QMC-Kahi Mohala Child/Adolescent Residential Program Application
- ☐ Recent psychiatric/mental health evaluation(s)
- ☐ Recent labs or other diagnostic records, if available
- ☐ Copies of guarantors ID, insurance card(s)
- ☐ Insurance Pre-Authorization

Referrals will be reviewed in the order received, patient/family may be contacted for additional information and/or screening for program benefit, and upon acceptance, the following will be required for admission:

- Custody/legal guardianship documents
- IEP/504 educational plan documents
- Immunization records
- Proof of TB clearance within the last 12 months (negative Quantiferon or negative single-step PPD skin test)
- Free of any symptoms of communicable illnesses (i.e. cold/flu)

PATIENT INFORMATION			
Patient Name:	**Gender:**	**DOB:**	**Age:**

PARENT/LEGAL GUARDIAN INFORMATION	
Parent/ Legal Guardian Name:	**Parent/ Legal Guardian Name:**
Relationship: Father Mother Other: _____	**Relationship:** Father Mother Other: _____
Address:	Address:
City: State: Zip:	City: State: Zip:
Best Phone Number:	Best Phone Number:
Email:	Email:
Family Access to Internet? YES NO	**Family Access to Internet?** YES NO

INSURANCE INFORMATION	
Primary Insurance:	Subscriber Member #:
Subscriber Name:	Subscriber Date of Birth:
Secondary Insurance:	Subscriber Member #:
Subscriber Name:	Subscriber Date of Birth:

CLINICAL INFORMATION SECTION
Reason for Requested Admission (include brief summary of past and current symptoms, with behaviors)

PSYCHIATRIC AND MEDICAL DIAGNOSES

CURRENT MEDICATIONS			
Name	**Dosage**	**Schedule**	**Route**
Allergies:			**NONE**
Preferred Outpatient Pharmacy:			

CURRENT/RECENT BEHAVIORAL AND EMOTIONAL ISSUES					
Injury to Self:	NO	YES*	**Family Conflict/Dysfunction:**	NO	YES*
Aggression toward Others:	NO	YES*	**CWS Involvement:**	NO	YES*
Inappropriate Sexual Behaviors:	NO	YES*	**Legal Issues:**	NO	YES*
Enuresis/Encopresis:	NO	YES*	**Difficulties with ADLs:**	NO	YES*
Runaway/Elopement:	NO	YES*	**Truancy/Suspensions:**	NO	YES*
**** If YES, specify:***					

COMMUNITY-BASED CARE PROVIDERS/PARTNERS	
Outpatient Therapist:	Phone Number:
Outpatient Psychiatric Provider:	Phone Number:
Primary Care Provider:	Phone Number:
Probation Officer:	Phone Number:
Care Coordinator/Case Worker:	Phone Number:
Other:	Phone Number:

ACADEMIC INFORMATION	
Current School:	**Grade:**
School Accommodations: *Please send any current plans/documents* NONE 504 Plan IEP Other (please describe): _____	

TREATMENT PLANNING SECTION Treatment Goals for Residential Program
1.
2.
3.
Other Comments:

ANTICIPATED DISCHARGE PLAN		
Will the patient return to current outpatient provider following discharge?	YES	NO*
**** If NO, specify discharge needs:***		

RESIDENTIAL PROGRAM – ADDITIONAL CARE NEEDS			
Special Diet:	NO	YES*	**** If YES, specify:***
Language/Interpreter Needs:	NO	YES*	**** If YES, specify:***
Medical Needs:	NO	YES*	**** If YES, specify:***
Mobility Needs:	NO	YES*	**** If YES, specify:***
Additional Relevant Information:			

WILLINGNESS TO ENGAGE IN TREATMENT		
QMC-Kahi Mohala is a **voluntary** hospital-based residential program. Active engagement in treatment is necessary to reach treatment goals, this includes participation of the family in weekly family therapy.		
Is Parent/Legal Guardian supportive of the admission?	YES	NO
Is Parent/Legal Guardian willing to participate in weekly family therapy?	YES	NO
If older than 15 years old, does the youth consent to participate in treatment?	YES	NO

REFERRING PROVIDER SIGNATURE		
Full Name, Title/Credentials	**Provider Signature**	**Date**

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