The Institute for Human Services
Ending the Cycle of Homelessness

IHS EMERGENCY REFERRAL FORM

Women and Children Shelter
546 Kaaahi Street
Honolulu, HI 96817
Phone: 808-447-2800
Fax: 808-841-3315

Sumner Men's Shelter
350 Sumner Street
Honolulu, HI 96817
Phone: 808-447-2900
Fax: 808-841-3315

Referral Organization:_____ **Individual Being Referred:**_____
Address:_____ **DOB:**_____ ☐**M** ☐**F** ☐**Trans**
Contact Person:_____ **Height/Weight:**_____**ft.** _____**in.**_____**lbs.**
Phone:_____ **Fax:**_____ **Veteran Status:**_____ **Legal Status:**_____

Date referral sent:_____ **Date of last COVID test:**_____ **Results:**_____
Vaccines Record:☐JANSSEN ☐PFIZER ☐MODERNA 1st dose:_____ 2nd dose:_____

Physician: _____ **Physician Contact Number**: _____

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
5. History of substance abuse/chemical dependency? ☐YES ☐NO If yes, list substances:_____
6. Drug Screen Results? ☐ Pos. for_____☐Neg
7. History of smoking? ☐YES quit date: _____ ☐NO
8. History of suicidal behavior?_____
9. Length of current hospital stay?_____
10. Reason/dates of last admit(s)?_____
11. Current Mental Health CM or PO:_____ Contact #_____
12. Length of time in state of Hawaii:_____

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

Walk at least 30 feet? ☐YES ☐NO Feeds self ? ☐YES ☐NO Toilet self? ☐YES ☐NO Bathe self? ☐YES ☐NO
Maintain good hygiene? ☐YES ☐NO Able to prep simple meals independently? ☐YES ☐NO
Ambulatory aides (wheelchair/walker)? ☐YES ☐NO If yes, able to transfer independently? ☐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? ☐YES ☐NO _____

Other Comments:

_____
_____
_____

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The purpose of this Emergency Referral form is to ensure that individuals being referred are appropriately accommodated and will receive proper attention.

Location client will be discharged to:_____
Contact Name and Number:_____

Health Plan:_____ **Member #:**_____
Service Coordinator:_____ **Contact Number:**_____

Medical Transport (to and from shelter) –
Scheduled with (agency/company):_____
Contact Individual:_____ Contact #:_____

Medication List:

Name	Dose/Route	Frequency	Prescribing Physician	# of tabs provided	Refillable?	Refill Pharmacy
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	
					☐YES ☐NO	

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: _____