Mailing: P.O. Box 29819 Hon, HI 96820
Email: services@kokuasupport.org
Website: www.kokuabehavioralhealth.org
PH: (808) 847-4227
FAX: (808) 842-0044
Hours: M-TH 9:00AM – 2:00PM

Kokua Support Services

A Path for a Better Tomorrow

SUBSTANCE ABUSE TREATMENT

REFERRAL FORM

A non-profit community service agency

Date:

Referred By (Circle One): Case Manger / Family / Probation/Parole Officer / Friend / Other: _____

PERSONAL

Last name | First | Middle/Maiden | Birth Date:

Address | City | Island | Zip Code | Social Security #

Gender: M: ☐ F: ☐ | Marital Status - Circle One: Single Married Separated Divorced

Reason for Referral: | Clients Contact #:

Behavioral Health Insurance Carrier:

LEGAL & DRUG

LIST CHARGES/VIOLATIONS (PAST, PRESENT, PENDING) CONVICTION DATES, & OUTCOMES

ALCOHOL/DRUG USE: (List Substance, Onset Age, Current Amount used, and date of last use) / TREATMENT HISTORY, if any

COLLATERAL/MEDICAL/PSYCHIATRIC

Does the client have ANY history of violence? Yes ☐ No ☐

If Yes, Please explain: _____

Are you working? Yes ☐ No ☐ **Name of Employer:**_____

Circle One: Full Time / Part Time MONTHLY NET (take home) INCOME: $_____

PSYCHIATRIC CONDITIONS and/or MEDICAL CONDITIONS:

List medical conditions and any medications being taken:

List any psychiatric diagnosis and any medications being taken:

REFERRING PERSONS INFORMATION

Name: _____

Title / Relation:

_____

Organization:

_____

Contact Information:

Phone: _____

Fax: _____

Email: _____

Signature: _____

All of the above information is required to process referrals for entrance into substance abuse treatment services