The Kahala Clinic for Children & Family

Pediatrician Referral Information

Name: _____ E-mail: _____

Phone: _____ Fax: _____

_____

Patient Information

Name/Gender: _____ Grade: _____

Date of Birth: _____ Phone: _____

Insurance:: _____ E-mail: _____

Reason for Referral

_____

_____

_____

_____

_____

Interventions Tried

☐Parenting education
☐Medical work-up (please describe below)
☐Therapy
☐Medication
☐Tutoring
☐504 MP/IEP

☐Behavior Plan (please attach)
☐Home-School Daily Behavior Log (please attach)
☐Assistive Technology (please describe) _____

_____

☐Other: _____

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PH: 808.888-5228 FAX: 808..732.6433 WEB: www.kahalaclinic.org

_____

Request

☐Behavioral Health Evaluation ☐Psychoeducational Testing

Other Relevant Information

Thank you for the referral. Please have the parent **contact our office** so that we may collect other additional information and ask them to **mention that they have been referred by you.**

We will do our best to accommodate. It would be helpful if they are made aware that we often have a waitlist. If this is an urgent matter, we recommend they continue to explore other options in the interim.