# Kasha Kim Psychological Services

**Mailing Address:** 1441 Kapiolani Blvd Ste 1114, Honolulu, Hawai'i 96814
**Secure Email:** contact@kashakimpsychologicalservices.com
**Website:** www.kashakimpsychologicalservices.com
**Phone:** (808) 393-5909
**Fax:** 18086630516


# Patient Referral Form

## PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Preferred Phone: _____

Email (Optional): _____

Preferred Contact Method: ☐ Phone ☐ Text (if permitted) ☐ Email

Insurance Company: _____

Member ID (Optional): _____

## REFERRING PROVIDER INFORMATION

Provider Name: _____

Practice/Clinic: _____

Phone: _____

Fax: _____

Email: _____

Preferred Method of Communication: ☐ Fax ☐ Phone ☐ Secure Email

## REASON FOR REFERRAL

(Check all that apply)

☐ Anxiety

☐ Depression

☐Trauma / PTSD

☐Autism Spectrum Disorder

☐ADHD

☐Developmental Disorder

☐Disruptive Behaviors

☐Parent-Child Relationship Issues

☐ Stress Management

☐ Adjustment Difficulties

☐ Grief / Loss

☐ Military / Veteran Concerns

☐ Behavioral Health Consultation

☐ Other: _____

## CLINICAL CONCERNS

Primary Diagnosis (if known):

_____

Reason for Referral / Clinical Summary:

_____

_____

## URGENCY

☐ Routine (Appointment within 2–4 weeks)

☐ Priority (Appointment within 1–2 weeks)

☐ Urgent (Please contact our office directly)

Note: This practice is not a crisis service. If the patient is experiencing a psychiatric emergency or is at imminent risk of harm, please direct them to the nearest emergency department or call 911.

## ATTACHMENTS INCLUDED

(Check all that apply)

☐ Office Visit Notes

☐ Medication List

☐ Relevant Medical Records

☐ Psychological Records

☐ Insurance Information

☐ Release of Information

☐ Other: _____

## PATIENT AWARENESS

☐ The patient has been informed of this referral.

☐ The patient has agreed to be contacted by Kasha Kim Psychological Services LLC.

## COMMUNICATION WITH REFERRING PROVIDER

With the patient's written authorization, our office is happy to:

☐ Confirm receipt of referral

☐ Confirm completion of intake

☐ Coordinate treatment recommendations

☐ Provide consultation as clinically appropriate

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Referring Provider Signature: _____

Date: _____

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## FAX TO:

Kasha Kim Psychological Services LLC

Fax:____18086630516_____

For questions or consultation, please call: _____(808) 393-5909_____

Thank you for your referral and the opportunity to collaborate in your patient's care.