HINA MAUKA

OISC Defendant Referral

Please Fax to:
(808) 247-6507
Att: Angelique Matutino

Date _____

Client Name_____ Phone # _____

DOB_____ Pre-trial Officer_____ Phone # _____

Attorney_____ Phone #_____

Do you have insurance? Y N Private or QUEST_____

Name of insurance carrier?_____

Have you been assessed or treated at Hina Mauka? Y N When_____

Do you have a medical diagnosis? Y N What is it_____

_____

Are you on any medications? Y N Current medications _____

_____

Do you have a psychiatric diagnosis? Y N What is it_____

_____

Are you on any medications? Y N Current medications _____

_____

Do you have any pending legal cases/court dates? (i.e.) New charges? Y N

Please list _____

ORAS Outcome: ☐High ☐Medium ☐Low

PAT Outcomes: _____

Submit attached consent form for Pre-trial Officer with this referral. Please fax all referrals to: 247-6507 Attention Angelique Matutino

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(Hina Mauka use only: Hina Mauka will respond within 5 days to confirm receiving this referral)

Date referral received: _____ Date contacted PTO: _____

Date contacted Client _____ Assessment Date _____

Date referred back to PTO: _____ Comments: _____