Fax Cover Sheet

Hale Ola Kino Admission Requirements

For physicians, hospitals and other healthcare facilities

Date: ________________
To: Resident Care Manager, Hale Ola Kino
From:____
Re: (Patient's Name)
# of pages including cover sheet__________

The following items are required to be faxed to Hale Ola Kino PRIOR to admission. The originals need to be sent with the patient upon admission. Please complete the checklist below, attach necessary documents, and fax to 983-4499. If you have questions or need assistance please contact our Resident Care Manager at 983-4442.

	ADVANCE DIRECTIVES	*Check all that apply* ☐Healthcare POA ☐Financial POA ☐Living Will
	TB CLEARANCE	☐CXR ***ruling out TB*** must be **w/in last year** **OR** ☐Results of intermediate strength PPD, **2 step w/in last year**
	LAB WORK	☐CBC **w/in 30 days** ☐UA **w/in 7 days**
	H & P	Completed by physician **w/in 48 hrs prior to admission.**
	PASARR	Completed and signed by the physician **w/in 48 hrs prior to admission**.
	TRANSFER FORM	Completed and signed by the physician.
	THERAPY ORDERS/NOTES	Order from physician for therapy evaluation AND treatment. Progress notes from PT / OT / ST if applicable.
	ATTENDING PHYSICIAN	To follow at Hale Ola Kino: ______________________________ Phone: ______________________________ ☐ Notified required to see patient at Hale Ola Kino as follows: **ICF patients every 30 days x 3 then every 60 days** **SNF patients within 14 days of admission then every 30 days x 3 then every 60 days**
	RESPONSIBLE PARTY	Contact(s) for patient: Phone(s):
	CERTIFICATION FORM	Required if patient being admitted at SNF level of care. Must be signed by physician **w/in 48 hours prior to admission.**
	1147	Required if patient being admitted w/Medicaid coverage.
	DISCHARGE PLANS	When applicable.

NOTE: THIS INFORMATION IS INTENDED SOLELY FOR THE INDIVIDUAL OR THE ENTITY TO WHICH IT IS ADDRESSED, AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND/OR PROHIBITED FROM DISCLOSURE. IF THE READER OF THIS COMMUNICATION IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE AT (808) 983-4443 AND RETURN THE ORIGINAL MESSAGE TO *HALE OLA KINO 1314 KALAKAUA AVE. HONO, HI 96826 ATTN: MEDICAL RECORDS.* THANK YOU.