CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC
MAUI COUNTY

CCBHC Referral Form

Please Email, Fax, Mail, Or Deliver Referral Form To Either of our Locations:

Lahaina CCBHC
1830 S Honoapiilani Hwy (Just below Civic Center)
Lahaina, HI 96761
Phone: (808) 495-5113
Email: mauiwellness@doh.hawaii.gov
Fax: (808) 873-3551

Kahului CCBHC
53 S Puunene Ave, Suite 105
Kahului, HI,96732
Phone: (808) 873-3550
Email: mauiwellness@doh.hawaii.gov
Fax: (808) 873-3551

Referral Date: / /

Referring Information (completed by Person Making Referral)

Agency: _____ ☐ No Referring Agency ☐ Self-Referral

_____ *Name* _____ *Title* _____ *Phone Number* _____ *Email*

Adult Information (Complete if referral services are for an Adult)

_____ *Legal Name (First Last)* _____ *Date of Birth* ○Male ○Female *Gender*

_____ *Preferred Name* _____ *Gender Identity* _____ *Preferred Language*

Youth Information (Complete if referral services are for a Youth)

_____ *Legal Name (First Last)* _____ *Date of Birth* ○Male ○Female *Gender*

_____ *Preferred Name* _____ *Gender Identity* _____ *Preferred Language*

_____ *School* _____ *Grade*

Who does youth live with? ○Parents ○Relatives ○Foster Family ○Other: _____

Legal Guardian Information (Complete if referral services are for a Youth)

_____ *Name* _____ *Preferred Language*

_____ *Primary Phone Number* _____ *Secondary Phone Number* _____ *Email*

_____ *Mailing Address* _____ *City* _____ *State* _____ *Zip Code*

_____ *Home Address* ☐ Same as Mailing Address _____ *City* _____ *State* _____ *Zip Code*

Relationship to youth: ○Mother ○Father ○Grandparent ○Aunt/Uncle ○Other: _____

Background Questions

Has individual being referred been evaluated or treated for mental health or substance use disorder concerns before? ○Yes ○No ○I don't know

What services are desired (if known): ☐Resource Guidance ☐Supportive Counseling ☐Medication Management ☐Parenting classes, ☐Other _____

What are the concerns?