

MEDICAL REFERRAL ASSISTANCE OFFICE (MRAO)

PATIENT REFERRAL INFORMATION (PRI)

(PLEASE CHECK APPROPRIATE LINE(S) BELOW)

LOS ANGELES, CA HONOLULU, HI MANILA, PI

OUTPATIENT DIRECT ADMISSION MEDEVAC

INTAKE DATE: DAY: TIME:

LAST NAME: FIRST: MIDDLE INITIAL:

DATE OF BIRTH: AGE: GENDER (CHECK APPROPRIATE BOX): MALE FEMALE

MAILING ADDRESS:

RESIDENTIAL ADDRESS:

CONTACT NUMBERS: HOME WORK CELL OFF-ISLAND

EMAIL ADDRESS:

ITINERARY (PLEASE ATTACH A COPY OF YOUR CONFIRMED TRAVEL ARRANGEMENTS)

Table with 9 columns: (LEAVING) DEPARTURE DATE, FROM, TO, AIRLINE, FLIGHT NUMBER, DEPARTURE TIME, FINAL DESTINATION ARRIVED AT, ARRIVAL DATE, ARRIVAL TIME. Includes a section for (RETURNING) DEPARTURE DATE.

TRANSPORTATION REQUEST(S) (CHECK APPROPRIATE BOXES BELOW)

- (ARRIVAL) AIRPORT PICK UP AND TRANSPORTATION TO LODGING
(DEPARTURE) LODGING PICK UP AND TRANSPORTATION TO AIRPORT
GROUND TRANSPORTATION TO AND FROM LODGING TO: MEDICAL FACILITY, PHARMACY AND/OR DRUGSTORE

SPECIAL NEEDS REQUESTED: 1. 2. 3.

ACCOMPANYING ESCORT(S) (ANYONE BELOW 21 YEARS OF AGE DOES NOT QUALIFY AS AN ESCORT)

NAME: RELATIONSHIP:

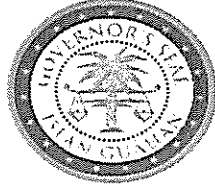
NAME: RELATIONSHIP:

AFFECTED BY ANY COMMUNICABLE DISEASE? NO YES (Please State)

LODGING CONFIRMED? NO YES (Please Provide Information Below)

NAME OF LODGING: CONTACT #

ADDRESS:



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REFERRING PHYSICIAN (ON-ISLAND)(ATTACH COPY OF REFERRAL)

NAME: \_\_\_\_\_

ACCEPTING PHYSICIAN (OFF-ISLAND):

NAME: \_\_\_\_\_

ACCEPTING MEDICAL FACILITY (OFF-ISLAND):

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HEALTHCARE INSURANCE COVERAGE (CHECK APPROPRIATE BOX(S):

- MIP      MEDICAID      MEDICARE      TAKE CARE  
NET CARE      SELECT CARE      STAYWELL      OTHER \_\_\_\_\_

EMERGENCY CONTACT:

NAME (ON-ISLAND): \_\_\_\_\_ CONTACT # \_\_\_\_\_ RELATION: \_\_\_\_\_

NAME (OFF-ISLAND): \_\_\_\_\_ CONTACT # \_\_\_\_\_ RELATION: \_\_\_\_\_

THE GUAM MEDICAL REFERRAL ASSISTANCE OFFICE (MRAO) WILL ONLY PROVIDE TRANSPORTATION ASSISTANCE TO AND FROM THE AIRPORT, TRANSPORTATION ASSISTANCE WITHIN A FIVE (5) MILE RADIUS TO AND FROM THE MEDICAL FACILITIES, PHARMACIES AND/OR DRUGSTORES FROM YOUR LODGING. THIS ASSISTANCE IS STRICTLY LIMITED FOR YOUR MEDICAL APPOINTMENTS AND/OR TREATMENTS. MRAO WILL NOT PROVIDE SERVICES TO OR FROM PRIVATE RESIDENCES.

PLEASE NOTE: FOOD LODGING, CAR RENTAL AND PERSONAL NEEDS ARE AT YOUR OWN EXPENSE

I HEREBY AUTHORIZE THE GUAM MEDICAL REFERRAL ASSISTANCE OFFICE (MRAO) TO RELEASE ALL PROTECTED HEALTH INFORMATION (PHI) IN ACCORDANCE WITH THE PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPPA) AND PUBLIC LAW 34-21.

AUTHORIZED BY:

PRINT NAME: \_\_\_\_\_ SIGN NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

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FOR OFFICIAL USE ONLY:

COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_