KŪ ALOHA OLA MAU Guest Medication Form

1130 N. Nimitz Hwy., C302 Honolulu, Hawaii 96817
Honolulu (808) 538-0704 Fax#(808) 538-0474
Hilo (808) 961-6822 Fax# (808) 934-9360

Form Prepared By: **Date Prepared:**

Personal Data:

Patient Name: _____

Birth Date: _____ **Ethnicity:** _____

Height: _____ **Weight:** _____ **Hair:** _____ **Eyes:** _____

Visible Distinguishing Characteristics such as tattoos, etc.:

_____

_____

Type of Photo Identification Card:

Clinic Treatment Information:

Home Clinic: _____

Address: _____

_____

Telephone: ( ) _____ **Facsimile Number: ( )** _____

Contact Staff Person(s): (specify nurse or counselor) _____

Dose: _____**mgs**

Pick Up Schedule:

_____

Last Day in Home Clinic:

_____

# of Travel Dose(s) Given: _____

Date(s) of travel dose(s): _____

Travel Dose: _____**mgs.**

First Day in Receiving Clinic:

_____

Last Day in Receiving Clinic: _____

Travel Dose Required(amount & date):

_____

Date Back in Home Clinic: _____

Other information (patient is transferring for admission, medical condition, comments, or special instructions): _____

Travel Data:

Temporary Telephone Number: _____

Temporary Residence: _____

_____

Reason for Travel: _____

Receiving Clinic Name: _____

Receiving Clinic Address: _____

_____

Receiving Clinic Telephone: ( ) _____**Receiving Clinic Facsimile: ( )** _____

Contact Staff Person(s): (specify nurse or counselor) _____

Cost: **$25 for first day dose and paperwork***

$15 for each dose after the first day*

***Payable in full prior to first medication. No personal checks/credit cards accepted.**

Physician's Signature		**Date Signed:**	