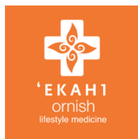

'Ekahi Ornish Physician Referral Form

Please complete and fax to: **(808) 447 – 0571**

Please include Lipid Panel, HbA1c, EKG, and last consultation note with medical history and current medications.
Please provide prescription for Lipid Panel and HbA1c **pre-program** (if no draw in the last 3 months) and **post-program**.

Patient Name:_________________________________ **Patient DOB:**_______________

Patient Email: (optional) ____________________________ **Patient Phone Number:**______________

Intensive Cardiac Rehab	**Expanded Eligibility**	**Cardiac Risk Factors**
Eligible Insurance ○ Medicare FFS ○ Medicare Advantage ○ HMSA PPO/HMO ○ HMSA Fed 87	Eligible Insurance ○ HMSA PPO/HMO	Eligible Insurance ○ HMSA PPO/HMO
Please √ **mark** at least **1** or more: ☐ **Post MI- Within the past 12 months** Date: ___/___/___ (MM/DD/YYYY) ☐ **Cardiac Surgery/Procedures** Date: ___/___/___ (MM/DD/YYYY) ☐ Heart Transplant ☐ Xenogenic heart valve ☐ Prosthetic Heart Valve ☐ Coronary Angioplasty ☐ Coronary Angioplasty with Implant and Graft ☐ Post Aortocoronary Bypass Graft ☐ Stable Angina	Please √ **mark** at least **1** or more: ☐ **Diagnosed with Coronary Artery Disease (CAD)** ☐ **Diagnosed with Congestive Heart Failure (CHF)** ☐ **Diagnosis of Metabolic Syndrome defined as 3 of the following:** ☐ Abdominal Obesity (waist >40 inches for men, waist>35 inches for women) ☐ Triglycerides>150mg/dL ☐ Taking medication for low HDL or HDL<40 mg/dL for men, <50mg/dL for women ☐ Blood pressure greater than or equal to 130/85 mmHg, or taking anti-hypertensive medication ☐ Fasting blood sugar greater than or equal to 100mg/dL	Please √ **mark** at least **2** or more: ☐ **Family history or personal history of CHD: first-degree relative (parents, siblings)** ☐ **Age (males > 45, females > 55)** ☐ **History of tobacco use but current tobacco non-user for at least 2 months** ☐ **BP > 130/85 or on medications** ☐ **Low HDL-C < 40 or on medication** ☐ **Elevated lipoprotein: Lp (a) > 30 or on medications** ☐ **Total cholesterol > 200 or on medication** ☐ **LDL > 100 or on medications** ☐ **High-sensitivity C-reactive protein >3 mg/dL and < 10 mg/dL** ☐ **Obesity:** ☐ BMI > 30 ☐ Waist to hip ratio greater than or equal to 1.0 for men, 0.85 for women ☐ Waist circumference > 40 inches for men, >35 inches for women)

*Exclusions: current smoker, dementia, current substance abuse or drug abuse, history of psychiatric disorder without documentation of a minimum of at least 1-year stability

I authorize my patient to enroll in the 'Ekahi Health System Intensive Cardiac Rehabilitation Program.
I understand that I will continue to provide regular medical care to my patient throughout the duration of the program.

Name of Physician (please print): ____

Physician Signature: ____ Date: ____________