'Ekahi Health Physician Referral Form

Please complete and fax this form to (808) 447-0571.

Thank you for your interest in 'Ekahi Health's prevention and wellness programs for your patient. Please include applicable labs, past medical history, and current medications along with this form and fax to 'Ekahi Health at (808) 447-0571.

Patient Information

Patient Name: ____________________________ Date of Birth: ____ /____ / _______

Home Phone: ____________________________ Email (optional): __________________________

Male Female

The **'Ekahi Wellness** program includes individual consultations and group sessions with our nurse practitioners, clinical pharmacists, behavioral health specialists, registered dietitians, certified diabetes educators, exercise physiologists, and stress management specialists.

Please check the box to **opt** your patient out of medical management

Please check **all** diagnoses that apply:

- Type II Diabetes
- Type I Diabetes
- Hypertension
- Dyslipidemia
  - Elevated total cholesterol
  - Elevated LDL
  - Elevated Triglycerides
  - Depressed HDL
- Obesity
  - BMI > 30
  - Waist to hip ratio greater than or equal to 1.0 for men or 0.85 for women
  - Waist circumference >40 inches for men or >35 for women

'Ekahi Health Center
500 Ala Moana Blvd Suite 6-D
Honolulu, HI 96813
P: (808) 777-4000 | F: (808) 447-0571.

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ornish
lifestyle medicine™

Patient Name: ______________________________

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Intensive Cardiac Rehab Eligible Insurance ○ Medicare FFS ○ Medicare Advantage ○ HMSA PPO/HMO ○ HMSA Fed 87	**Expanded Eligibility** Eligible Insurance ○ HMSA PPO/HMO	**Cardiac Risk Factors** 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 ☐ **Diagnoses with Congestive Heart Failure (CHF)**	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 from Ornish Lifestyle Medicine include: 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 following checked 'Ekahi Health prevention and wellness program(s).
I understand that I will continue to provide regular medical care to my patient throughout the duration of the program(s).

'Ekahi Ornish Lifestyle Medicine

'Ekahi Wellness

Name of Physician (please print): ____

Physician Signature: ____ Date: ______________

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