Ornish Lifestyle Medicine™ Program
PHYSICIAN REFERRAL FORM

HAWAIʻI PACIFIC HEALTH | STRAUB MEDICAL CENTER
CREATING A HEALTHIER HAWAIʻI

ornish lifestyle medicine™

Patient Name: _____

Patient Date of Birth: _____

Patient Phone Number: _____

Please mark all that apply only if you have one of the following insurance plans:

Any Medicare, HMSA FED, HMSA EUTF, HMSA Bluecard, MDX Humana/AARP, AETNA, HMAA, UHA, UHC, TRICARE Select or TRICARE for Life

CARDIAC EVENT

☐ **Post MI – within the past 12 months (I25.2)**
Date: ___/___/_____(MM/DD/YYYY)

☐ **Cardiac surgery/procedures**
Date: ___/___/_____ (MM/DD/YYYY)

- ☐ Heart transplant (Z94.1)
- ☐ Xenogenic heart valve (Z95.3)
- ☐ Prosthetic heart valve (Z95.2)
- ☐ Coronary angioplasty (Z98.61)
- ☐ Coronary angioplasty with implant and graft (Z95.5)
- ☐ Post aortocoronary bypass graft (Z95.1)
- ☐ Stable angina (I20.9)
- ☐ Valve repair (Z98.890)

☐ **Diagnosed with stable, chronic heart failure defined as LVEF ≤ 35% (CHF)**
Date:___/___/_____(MM/DD/YYYY)

- Other heart failure (I50.89)
- Chronic systolic (congestive) heart failure (I50.22)
- Chronic combined systolic (congestive) and diastolic (congestive) heart failure (I50.42)

Other ICD codes:_____

Please mark all that apply from group "A" or group "B" only if you have one of the following insurance plans:

HMSA HMO/PPO/QST or UHC QST

A (Mark at least one)

☐ **Diagnosed with coronary artery disease (CAD) with stable angina (I25.10)**

☐ **Diagnosis of metabolic syndrome, defined as any 3 of the following (E88.81):**

- o Abdominal obesity (waist > 40 inches for men, waist > 35 inches for women)
- o Triglycerides > 150 mg/dL
- o Taking medication for low HDL or HDL < 40 mg/dL for men, < 50mg/dL for women
- o Blood pressure ≥ 130/85 mmHg, or taking anti-hypertensive medication
- o Fasting blood sugar ≥ to 100 mg/dL

☐ **Post MI – within the past 12 months (I25.2)**
Date: ___/___/_____(MM/DD/YYYY)

☐ **Cardiac surgery/procedures**
Date: ___/___/_____ (MM/DD/YYYY)

- ☐ Heart transplant (Z94.1)
- ☐ Xenogenic heart valve (Z95.3)
- ☐ Prosthetic heart valve (Z95.2)
- ☐ Coronary angioplasty (Z98.61)
- ☐ Coronary angioplasty with implant & graft (Z95.5)
- ☐ Post aortocoronary bypass graft (Z95.1)
- ☐ Stable angina (I20.9)
- ☐ Valve repair (Z98.890)

☐ **Diagnosed with congestive heart failure (CHF)** Date:___/___/____(MM/DD/YYYY)

- Other heart failure (I50.89)
- Chronic systolic (congestive) heart failure (I50.22)
- Chronic combined systolic (congestive) and diastolic (congestive) heart failure (I50.42)

B (Mark at least two)

☐ **Family or personal history of CHD: First-degree relative (i.e. parents, full siblings) (Z82.49)**

☐ **Age (males > 45, females > 55) (Z91.89)**

☐ **History of tobacco use, but not current tobacco user for at least 2 months (Z87.891)**

☐ **Hypertension: blood pressure > or equal to 130/85 mmHg or taking anti-hypertensive medication (I10)**

☐ **Low HDL-C: < 40 mg/dL or on medication for lipid therapy (E78.5)**

☐ **Elevated lipoprotein: Lp (a) > 30 mg/dL or on medications for elevated lipids (E78.4)**

☐ **Total cholesterol > 200 mg/dL or on medication for elevated lipids (E78)**

☐ **LDL > 100 mg/dL or on medications for elevated lipids (E78)**

☐ **High-sensitivity, C-reactive protein > 3 mg/dL and less than 10 mg/dL (R79.82)**

☐ **Obesity, defined as one of the following (E66.9):**

- o BMI > 30
- o Waist : hip ratio ≥ 1.0 for men; ≥ 0.85 for women
- o Waist circumference (>40 inches for men, >35 inches for women)

The following patient information must be faxed with this form to 808-522-4134. For questions, call 808-522-4114.

- Latest lab results for lipid panel and hemoglobin A1c
- Electrocardiogram (EKG) tracing
- Echocardiogram results
- Stress test summary
- Progress notes

Exclusions: *Patients who currently smoke, abuse drugs or other substances, have dementia, a history of psychiatric disorder with less than 1 year of documented stability, or unstable angina, are not eligible for the Ornish Lifestyle Medicine™ Program.*

I authorize my patient to enroll in the Straub Medical Center Intensive Cardiac Rehabilitation Program and will continue to provide regular medical care to my patient throughout the duration of the program.

Name of Physician (printed): _____

Physician Signature: _____ Date:_____