STRAUB CLINIC & HOSPITAL
An Affiliate of Hawai'i Pacific Health

ornish reversal program

**Patient Name:** _____

# Referral Form

**Patient DOB:**_____

**Please fax to (808) 522-4134 with this referral form:** Lipid Panel, A1C, Stress Test Summary, Echo, ECG and other relevant medical history unless available in Electronic Health Record. **Please provide prescription for Labs: Lipids and HgbA1c for the following 2 time points: pre-Program (if no draw in last 3 months) and post-Program.**

| **Eligible Insurance: Medicare/Medicare Advantage/HMSA HMO/PPO** | **Eligible Insurance: HMSA HMO/PPO** | **Eligible Insurance: HMSA HMO/PPO** |
|---|---|---|
| Select at least **1** or more of the following diagnosis: | Select at least **1** or more of the following diagnosis: | Select at least **2** or more of the following diagnosis: |
| ☐ **Post MI – Within the past 12 months** Date: ____/____/____(MM/DD/YYYY)<br><br>☐ **Less than eight weeks:**<br>☐ STEMI anterior wall (I21.09)<br>☐ STEMI inferior wall (I21.19)<br>☐ STEMI Rt Coronary Artery (I21.11)<br>☐ STEMI other sites (I21.29)<br>☐ STEMI Unspecified site (I21.4)<br><br>☐ **Post MI – more than eight weeks I25.2** Date: ____/____/____(MM/DD/YYYY)<br><br>☐ **Cardiac Surgery/Procedures** Date: ____/____/____ (MM/DD/YYYY)<br>☐ Heart Transplant (Z94.1)<br>☐ Xenogenic heart valve (Z95.3)<br>☐ Prosthetic Heart Valve (Z95.2)<br>☐ Coronary Angioplasty (Z98.61)<br>☐ Coronary Angioplasty (Z98.61)<br>☐ Coronary Angioplasty with Implant & Graft (Z95.5)<br>☐ Post Aortocoronary Bypass Graft (Z95.1)<br>☐ Stable Angina (I20.9) | ☐ **Diagnosed with Coronary Artery Disease (CAD):**<br>○ Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (I25.10)<br>○ Atherosclerosis of Coronary Artery Bypass Graft without Angina Pectoris (I25.810)<br>○ Atherosclerosis of Native Coronary Artery of Transplanted heart without Angina Pectoris (I25.11)<br>○ Atherosclerosis of Bypass Graft of Coronary Artery of Transplanted heart without Angina Pectoris (I25.812)<br>☐ **Diagnosed with congestive heart failure (CHF):**<br>○ Heart Failure, unspecified (I50.9)<br>○ Left Ventricular Failure (I50.1)<br>○ Unspecified Systolic (I50.20)<br>☐ **Diagnosis of metabolic syndrome, defined as any 3 of the following (E88.81):**<br>○ Abdominal obesity (waist > 40 inches for men, waist > 35 inches for women).<br>○ Triglycerides > 150 mg/dL.<br>○ Taking medication for low HDL or HDL < 40 mg/dL for men, > 50mg/dL for women.<br>○ Blood pressure ≥ 130/85 mmHg, or taking anti-hypertensive medication.<br>○ Fasting blood sugar ≥ to 100 mg/dL | ☐ Family or personal history of CHD: First-degree relative (i.e. parents, full siblings). (Z82.49)<br>☐ Age (males > 45, females > 55)<br>☐ History of tobacco use but current tobacco non-user for at least 2 months<br>☐ Hypertension: blood pressure > 130/85 mmHg or taking anti-hypertensive medication. (I10)<br>☐ Hyperlipidemia (E78.5)<br>○ Low HDL-C: < 40 mg/dL or on medication for lipid therapy<br>○ Elevated lipoprotein: Lp (a) > 30 mg/Dl or on medications for elevated lipids.<br>○ Total cholesterol > 200 or on medication for elevated lipids.<br>○ LDL > 100 or on medications for elevated lipids.<br>☐ High-sensitivity C-reactive protein > 3 mg/dL and less than 10 mg/dL (E79.82)<br>☐ **Obesity, defined as one of the following (E66.9):**<br>○ BMI > 30<br>○ Waist:Hip Ratio ≥ 1.0 for men; ≥ 0.85 for women<br>○ 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 Straub Clinic & Hospital 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: _____