1319 Punahou Street
Honolulu, Hawai'i 96826-1001

KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN
An Affiliate of Hawai'i Pacific Health

808-983-6000
www.kapiolani.org

N.E.W. Keiki (Nutrition + Exercise + Weight Management)

PHYSICIAN REFERRAL FORM

☐ Patient Name: _____DOB:_____ Male/Female
Last First M.I. (mm/dd/yy)

Parent(s)/guardian(s) Name(s):_____

Address:_____ City:_____ Zip:_____

Phone: _____ Email: _____

Insurance: _____ Policy #:_____

☐ **Date of most recent Vital Signs:**_____

Wt: _____lb/kg Ht: _____in/cm BMI: _____ BMI %: _____ BP: _____

☐ **Obesity-related Comorbidity(ies)** (circle all that apply):

Acanthosis Nigricans	*Asthma*	*Diabetes Mellitus*	*Non-alcoholic Fatty Liver Disease/Elevated LFTs*
Exercise Intolerance	*Hyperlipidemia*	*Hypertension/PreHTN*	*Metabolic Syndrome/Insulin Resistance*
Pre-Diabetes	*Sleep Apnea*	*Other:*_____	*None identified at this time*

☐ **Comments/Pertinent Past Medical History:**

☐ **ATTACH REQUIRED SCREENING LAB DATA*** (*results within the past 12 months)

- Fasting lipid screen
- Fasting glucose,
- HbA1c
- ALT/AST

Referral Physician Information

Physician: _____ Phone: _____

Address: _____ Fax: _____

_____ Email:_____

The above named patient is cleared to participate in an exercise program.

_____ _____
Physician Signature Date

Please submit completed referral form and labs by FAX (808-983-6056)

Questions? Contact us 808-983-8500 x2 or visit: https://www.hawaiipacifichealth.org/kapiolani/services/new-keiki/