

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

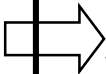
Referral Physician Information

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/>