

360° WEIGHT MANAGEMENT CENTER REFERRAL FORM

98-1079 Moanalua Road, Suite 490 • Aiea, HI 96701
Telephone 808-485-4173 • Fax 808-485-3164

Confirmed Patient Appointment: Date _____ Time _____ with _____

► PATIENT INFORMATION

Last Name _____ First Name _____

Birth Date (mm/dd/yyyy) ____/____/____ Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mailing Address _____

Is special accommodation required? Yes ___ No ___

Does patient use any assistive devices Yes ___ No ___

If yes, please indicate: Walker ___ Cane ___ Scooter ___ Other, explain: _____

► INSURANCE INFORMATION

Primary Insurance _____ Subscriber _____ Subscriber # _____ Group # _____

Secondary Insurance _____ Subscriber _____ Subscriber # _____ Group # _____

► REASON FOR REFERRAL

 Bariatric Surgery Weight Management**Presence of Co-Morbidities:**

- | | |
|--|---|
| <input type="checkbox"/> Diabetes – Glucose | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> GERD |

Height: _____ Weight: _____ BMI: _____

► REFERRING PHYSICIAN

Physician Name _____ Phone _____

Physician Signature _____ Fax _____

Please send supporting documents with referral:

- Radiology Reports (chest images)
- Doctor's Notes (past 3 months)
- Lab & Pathology Reports
- Medication List

Fax request and documents to 808-485-3164NOTE: Appointments are only scheduled when all documents are received.
Patients must bring a picture ID and insurance card(s).