'EKAHI wellness

Physician Referral Form

Thank you for your interest in 'Ekahi Wellness for your patient. To get them started, please fax this form to (808) 465 - 2505 with a legible copy of both sides of insurance card, current medical history, office notes, current medication list, and copies of current labs including metabolic panel, CBC, HbA1c, glucose tolerance test, urine microalbumin, and lipid panel.

Requesting diabetes management with emphasis in:

- ☐ Medical Management
- ☐ Exercise
- ☐ Behavioral Health
- ☐ Goal Setting / Overcoming Barriers
- ☐ Nutrition Education
- ☐ Stress Management

Patient Information:

Patient Name: _____ Date of Birth: ____ /____ / _____ Insurance: _____

Home Phone: _____ Alt Phone: _____

☐ Male ☐ Female

Does patient have clearance to exercise? ○ **Yes** ○ **No**

Exercise Restrictions: _____

Diagnosis (Unable to Provide Services Without Diagnosis):

- ☐ **250.00/E11.9** T2DM Controlled
- ☐ **250.01/E10.9** T1DM Controlled
- ☐ **790.22/R73.02** Abnormal Glucose Tolerance
- ☐ **250.02/E11.65** T2DM Uncontrolled
- ☐ **250.03/E10.65** T1DM Uncontrolled

Additional Diagnosis:

- ☐ **272.4/E78.5** Hyperlipidemia
- ☐ **401.1/I10** Hypertention
- ☐ **277.70/E88.81** Dysmetabolic Syndrome
- ☐ **278.00/E66.09** Obesity
- ☐ **278.01/E66.01** Morbid Obesity
- ☐ **585.9/N18.9** Chronic Renal Failure

I certify that it is medically appropriate to refer the above patient to Ekahi Wellness for evaluation and treatment.

_____ _____ _____

Physician Name (Print) NPI: Phone

_____ _____ _____

Physician Signature Date Fax