

Ornish Lifestyle Medicine Referral Form/MD Order

Please complete and fax to: (808) 932 – 3528. Questions? Call the Hilo team at (808) 932-3455.

Please include Lipid Panel, HbA1c, EKG, and last consultation note with medical history and current medications.
Please provide prescription for Lipid Panel and HbA1c **pre-program** (if no draw in the last 3 months) and **post-program**.

Patient Name: _____ Phone Number: _____ Patient DOB: _____

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:
<input type="checkbox"/> Post MI- Within the past 12 months Date: __/__/____(MM/DD/YYYY) <input type="checkbox"/> Less than eight weeks: <input type="checkbox"/> STEMI anterior wall (I21.09) <input type="checkbox"/> STEMI inferior wall (I21.19) <input type="checkbox"/> STEMI Rt Coronary Artery (I21.11) <input type="checkbox"/> STEMI other sites (I21.29) <input type="checkbox"/> STEMI unspecified site (I21.4) <input type="checkbox"/> Post MI- more than eight weeks (125.2) Date: __/__/____(MM/DD/YYYY) <input type="checkbox"/> Cardiac Surgery/Procedures Date: __/__/____(MM/DD/YYYY) <input type="checkbox"/> Heart Transplant (Z94.1) <input type="checkbox"/> Xenogenic heart valve (Z95.3) <input type="checkbox"/> Prosthetic Heart Valve (Z95.2) <input type="checkbox"/> Coronary Angioplasty (Z9861) <input type="checkbox"/> Coronary Angioplasty with implant and Graft (Z95.5) <input type="checkbox"/> Post Aortocoronary Bypass Graft (Z95.1) <input type="checkbox"/> Stable Angina (I20.9)	<input type="checkbox"/> Diagnosed Coronary Artery Disease (CAD): <input type="checkbox"/> Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris (I25.10) <input type="checkbox"/> Atherosclerosis of Coronary Artery Bypass Graft without Angina Pectoris (I25.810) <input type="checkbox"/> Atherosclerosis of Native Coronary Artery of Transplanted heart without Angina Pectoris (I25.11) <input type="checkbox"/> Atherosclerosis of Bypass Graft of Coronary Artery of Transplanted heart without Angina Pectoris (I25.812) <input type="checkbox"/> Diagnosed Congestive Heart Failure (CHF) <input type="checkbox"/> Heart Failure, unspecified (I50.9) <input type="checkbox"/> Left Ventricular Failure (I50.1, I50.22) <input type="checkbox"/> Unspecified Systolic (I50.20) <input type="checkbox"/> Diagnosis of Metabolic Syndrome defined as 3 of the following (E88.81): <input type="checkbox"/> Abdominal Obesity (waist >40 inches for men, waist>35 inches for women) <input type="checkbox"/> Triglycerides >150mg/dL <input type="checkbox"/> Taking medication for low HDL or HDL<40 mg/dL for men,>50mg/dL for women <input type="checkbox"/> Blood pressure ≥130/85 mmHg, or taking anti-hypertensive medication <input type="checkbox"/> Fasting blood sugar ≥100mg/dL	<input type="checkbox"/> Family history or personal history of CHD: first-degree relative (parents, siblings). (Z82.49) <input type="checkbox"/> Age (males > 45, females > 55) <input type="checkbox"/> History of tobacco use but current tobacco non-user for at least 2 months <input type="checkbox"/> Hypertension: blood pressure >130/85 mmHg or on anti-hypertension medications (I10) <input type="checkbox"/> Hyperlipidemia (E78.5) <input type="checkbox"/> Low HDL-C: < 40 mg/dL or on medication for lipid therapy <input type="checkbox"/> Elevated lipoprotein: Lp (a) >30mg/dL or on medications for elevated lipids. <input type="checkbox"/> Total cholesterol >200 or on medication for elevated lipids <input type="checkbox"/> LDL > 100 or on medications for elevated lipids <input type="checkbox"/> High-sensitivity C-reactive protein >3 mg/dL and <10 mg/dL (E79.82) <input type="checkbox"/> Obesity, defined as 1 of the following (E66.9): <input type="checkbox"/> BMI > 30 <input type="checkbox"/> Waist:Hip ratio ≥ 1.0 for men, ≥0.85 for women <input type="checkbox"/> 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 Hilo Medical Center Ornish Lifestyle Medicine, an Intensive Cardiac Rehabilitation program in which sessions are limited to 72, 1-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

Exercise Treatment Prescription

- Progressive exercise training 2-3 times per week, 30-60 minutes per session, utilizing cardio, other conditioning activities and appropriate home program supplement.
- Initiation of light upper/lower body resistance training with progression as tolerated and as specific to patient needs.
- Education/coaching to promote an active healthy lifestyle and reduction of personal cardiovascular risk factors.

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: _____