Castle Medical Center
Surgical Weight Loss Institute
Adventist Health

640 Ulukahiki Street
Kailua, Hawai'i 96734-4498
Tel (808) 263-5176
Fax (808) 263-5309
Castlemed.org

Physician Referral Form for Bariatric Surgery

Patient Last Name: _____ First Name: _____

DOB: _____ Gender: ☐ M ☐ F Email: _____

Street Address: (mandatory) _____

P.0. Box (optional for mailing only) _____

City: _____ State: _____ Zip Code: _____

Tel. HM: _____ WK: _____ CEL: _____

Insurances accepted: HMSA, UHA, DMBA, HMA, HMAA, Medicare, MDX. Cash also accepted.

Subscriber: _____ Medical Insurance: _____ Primary Ins Policy #: _____

Subscriber: _____ Medical Insurance: _____ Secondary Ins Policy # _____

☐ HMO (PCP send referral letter to HMSA) Attach copy to referral form. ☐ PPO

Please calculate height and weight in metric using the following web link: ***http://www.medcalc.com/body.html***

Height (centimeters): _____ Weight (kilograms): _____ BMI: _____

If available, please attach all pertinent medical records that address the following questions:

1. Has patient been medically cleared for all co-morbidities? ☐ Yes ☐ No ☐ Enclosed
2. Has patient been evaluated for hypothyroidism or other endocrinopathology? ☐ Yes ☐ No ☐ Enclosed
3. Has patient received cardiac clearance for surgery? ☐ Yes ☐ No ☐ Enclosed
4. Has patient had an evaluation for h. pylori if patient was symptomatic for GERD or gastric reflux? ☐ Yes ☐ No ☐ Enclosed
5. Has patient completed a physician supervised diet with monthly weigh-ins? ☐ Yes ☐ No ☐ Enclosed
6. Has patient completed a supervised exercise program? ☐ Yes ☐ No ☐ Enclosed
7. Does this patient smoke cigarettes? _____ Packs Per Day _____ Years _____ If quit, When? _____

Referring Physician: _____ Phone No: _____ Fax: _____

Address: _____

_____ _____
Signature of Referring Physician Date

Fax Completed Referral to SWLI office: (808) 263-5309