Castle Medical Center
Adventist Health

The Hawai`i Center for Metabolic and Bariatric Surgery - Physician Referral Form

640 Ulukahiki Street
Kailua, HI 96734
Tel (808) 263-5176
Fax (808) 263-5309
Castlemed.org

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. Home: _____ Work: _____ Cell: _____

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

_____ Subscriber | _____ Medical Insurance | _____ Primary Insurance Policy#

_____ Subscriber | _____ Medical Insurance | _____ Secondary Insurance Policy#

☐ HMO ☐ PPO

Has Patient had Prior Bariatric Surgery? ☐ Yes ☐ No **If Yes:** ☐ Lap Band ☐ Gastric Bypass ☐ Sleeve

Date of Prior Surgery: _____

Diagnosis: ☐ Morbid Obesity (278.01) ☐ Other: _____

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

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

Referring Physician: _____ **Phone No:** _____ **Fax:** _____

Address: _____

X _____ _____ _____
Signature of Referring Physician **Date** **Time**

Fax Completed Referral Form to HCMBS Office: (808) 263-5309

Castle Medical Center Kailua, Hawaii

THCMBS-PHYSICIAN REFERRAL FORM

PATIENT ID

* 2 3 7 *

PHYSICIAN ORDER

FORM 5450 5/15