

**Endocrinology Clinic Form**

t: 705-876-5838 | f: 705-876-5156

PATIENT LABEL

Primary care provider: \_\_\_\_\_

Referring provider (if not the same): \_\_\_\_\_

CLIENT/PATIENT INFORMATION		
Name:	Address	
DOB (DD/MM/YYYY):	Phone #:	OHIP#:

TYPE OF REFERRAL
<input type="checkbox"/> Person <b>with</b> diabetes <input type="checkbox"/> Person <b>without</b> diabetes
Additional details:

CONDITION FOR REFERRAL					
<input type="checkbox"/> Type 1	<input type="checkbox"/> Type 2	<input type="checkbox"/> Gestational _____ weeks	<input type="checkbox"/> ICT	<input type="checkbox"/> IFG	<input type="checkbox"/> Newly diagnosed
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Hypothyroidism		<input type="checkbox"/> Thyroid Cancer	<input type="checkbox"/> Hypoglycaemia	<input type="checkbox"/> Adrenal Disease
<input type="checkbox"/> Other:					

LABS REQUIRED FOR REFERRAL
<input type="checkbox"/> For patients with suspected thyroid issues please include <b>TSH and Free T4 and Free T3</b> [within one (1) month]
<input type="checkbox"/> For patients with diabetes please include <b>HBA1C, urine ACR, Creatinine and Lipid Profile</b> [within three (3) months]
<input type="checkbox"/> For patients with symptoms of hypercalcemia please include <b>CA, 25 hydroxy vit D, and PTH</b> [within one (1) month]
<b>Please order the above labs if they have not been completed in the time-frame noted above.</b>

ATTACHMENTS TO REFERRAL
<input type="checkbox"/> Up to date medication list
<input type="checkbox"/> Known allergies
<input type="checkbox"/> Relevant labs and diagnostics
<input type="checkbox"/> Relevant consult notes

Referring Physician (please print):	Referring Physician Billing No.:
Referring Physician Signature:	Date (DD/MM/YYYY):
Phone #:	Fax #: