

DIABETES & ENDOCRINOLOGY CLINIC REFERRAL FORM

PATIENT INFORMATION (attach patient label)

Patient Name: _____	<input type="checkbox"/> M <input type="checkbox"/> F
ULI: _____	DOB: _____
Address: _____	Postal Code: _____
City, Province: _____	Home phone: _____
Email: _____	

REFERRING PHYSICIAN INFORMATION

Physician Name: _____
Practice ID: _____
Clinic Name: _____
Clinic Address: _____
Ph: _____ Fax: _____

**Reports are uploaded to Netcare*

Relevant History:

Please Note: We will fax the appointment date and time to your office and notify the patient by phone or letter. The patient may require labs to be completed prior to this appointment and a lab requisition will also be sent to the patient. We require 72-hour notice for cancellation or rescheduling of appointment.

Urgent
Reason for Urgency:

For triage of referrals please select from the following:

GENERAL ENDOCRINOLOGY

- Adrenal
- Bariatric Matters / Obesity
- Calcium / Parathyroid
- Diabetes Management
- Dyslipidemia
- Hypertension
- Osteoporosis
- Pituitary
- Reproductive - Female
- Reproductive - Male
- Thyroid Disorder
- Other

DIAGNOSTIC TESTING

- 24-hour ABPM
- 24-hour ABPM + Hypertension Consult

NOW OFFERING 24-hour ABPM – Booking within 1 week!

Referring Physician Signature: _____
 Date of Referral: _____