



Specialty Referral Form Endocrinology

Patient Information

First Name: _____ Last Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Language: _____
Insurance (please provider front/back copy): _____

Past Medical History

- Include most recent H&P
- Recent labs

Referring Office:

Referring Provider: _____ Referring Office: _____
Phone: _____ Fax: _____ City: _____ State: _____
Degree of Specialty involvement: ___ consultation ___ co-management ___ transfer of care
Reason for Referral: _____
Urgency: First Available Urgent *Please call directly for urgent referrals in addition to form

Specialty Specific Information: [Endocrinology]

Is patient being seen for diabetes:
Does patient have a glucometer? Yes _____ No _____

Is patient being seen for endocrinology issues:
Any related imaging? _____

Is patient being seen for osteoporosis?
Has patient had a recent bone density? Yes _____ No _____

Scheduling:

UPC Endocrinology and Diabetes Clinic will call patient directly to schedule appt once imaging and records are available and reviewed.