



Endocrinology Referral Form

Patient Name _____

D.O.B. _____

Phone Number _____

If a patient needs to be seen urgently, please indicate below on the referral form. If our providers deem the referral is urgent based on the information provided to us, our office will contact the patient directly to schedule an appointment. Once we receive and evaluate the urgent referral, we will contact the patient within 2-3 business days in most cases. We are generally unable to see referrals for diabetes on an urgent basis. Wait time for non-urgent endocrine consults may be approximately 6 months. For non-urgent referrals, we attempt to contact the patient directly to schedule the appointment within approximately one (1) week of our clinic receiving the referral.

While most endocrinology visits can wait this long for evaluation, there are some cases that should be evaluated sooner. Examples of urgent referrals include:

- Symptomatic hyperthyroidism
- New diagnosis of thyroid cancer
- New diagnosis of adrenal insufficiency
- New diagnosis of pituitary macroadenoma
- Uncontrolled endocrine conditions in pregnancy

Endocrinologist to be seen:

____ First available, either physician ____ Dr. Divya Pati ____ Dr. Julie Schommer

Please indicate the endocrine condition(s) for which the patient is being referred. Include the previous 6 months office notes, labs, and imaging. Please include any other pertinent information from any date.

____ Routine

____ Urgent (to be seen within 2-3 weeks in most cases)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acromegaly | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Premature Ovarian Failure |
| <input type="checkbox"/> Adrenal Nodule | <input type="checkbox"/> Hypoparathyroidism/
Hypocalcemia | <input type="checkbox"/> Prolactinoma |
| <input type="checkbox"/> Congenital Adrenal Hyperplasia | <input type="checkbox"/> Hypopituitarism | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> Cortisol Excess/Cushing's | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Thyroid Nodule(s) or Goiter |
| <input type="checkbox"/> Diabetes Insipidus | <input type="checkbox"/> Low Testosterone in Male | <input type="checkbox"/> Transgender Hormone Treatment |
| <input type="checkbox"/> Diabetes Mellitus of other or unknown type | <input type="checkbox"/> Neuroendocrine | <input type="checkbox"/> Turner Syndrome |
| <input type="checkbox"/> Gynecomastia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Type 1 Diabetes |
| <input type="checkbox"/> Hyperparathyroidism/
Hypercalcemia | <input type="checkbox"/> Pituitary Adenoma | <input type="checkbox"/> Type 2 Diabetes |

Additional Comments: _____

Referring Provider: _____ **Phone:** _____ **Fax:** _____

Please fax to 515-241-4057