Peterborough Regional Health Centre

Endocrinology Clinic Referral Form

t: 705-743-2121 x 2828 | f: 705-876-5840

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	
☐ Person **with** diabetes	☐ Person **without** diabetes
Additional details:	

CONDITION FOR REFERRAL					
☐ Type 1	☐ Type 2	☐ Gestational _____ weeks	☐ IGT	☐ IFG	☐ Newly diagnosed
☐ Hyperthyroidism	☐ Hypothyroidism		☐ Thyroid Cancer	☐ Hypoglycaemia	☐ Adrenal Disease
☐ Other:					

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

ATTACHMENTS TO REFERRAL
☐ Up to date medication list
☐ Known allergies
☐ Relevant labs and diagnostics
☐ Relevant consult notes

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