

Endocrinology Clinic Master Referral form

Patient Label/Stamp

Fax: 504.903.1605

Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Patient Label/Stamp is Not Available Please Complete the Following:

Patient's Name: _____ Date of Referral: ____/____/____

Date of Birth: ____/____/____ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email Address: _____

Indicate Reason for Referral:

255.9 Adrenal Disorders: Insufficiency*,
Tumor(s)*, Cushing Syndrome*,
Pheochromocytoma*
 **259.9 Carcinoid*, Gastrinoma*, Vipoma* or
Hypoglycemia* (GI Endocrine Tumors)**
 **275.9 Disorders of Bone and Mineral
Metabolism:** Hypercalcemia*, Hypocalcemia*,
Hyperparathyroidism*, Osteomalacia/Osteoporosis*

Disorders of Carbohydrate & Lipid Metabolism:

250.00 Diabetes Mellitus*†
 V45.85 Insulin Pump Status
 272.9 Lipid Disorders, Refractory*†

Disorders of Reproductive Function

629.9 Female*

Disorders of Reproductive Function

704.1 Hirsutism *
 628.9 Male*
 253.9 Pituitary Disorders*
 V72.83 Pre-op Endocrinologic Evaluation†

Thyroid Disorders:

790.99 Abnormal Thyroid Function Tests
 240.0 Goiter
 241 Thyroid nodule(s)
 242.90 Hyperthyroidism*
 244.9 Hypothyroidism, Refractory*†
 193 Thyroid Carcinoma*

783.1 Weight Gain

783.21 Weight loss

Other ICD: ___ Diagnosis: _____

*Complete the Endocrinology Appendices for These Indications for Referral and fax with this Master Referral Form.

†Referral from Primary Care Providers Only

Clinical History Relevant to this Referral: _____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ____/____/____ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 3/9/09