

Patient Label/Stamp

**Endocrinology Clinic**

**Fax: 504.903.1605**

**Fax this form with the Endocrinology Master Referral form when requesting an appointment.**

**Appendix: ADRENAL TUMORS**

The following test results are required for this referral (current within the past 6 months): serum Basic Metabolic Profile, renin and aldosterone (done simultaneously), 24 hour urine cortisol or dexamethasone suppression test, 24- hour urine for catecholamines, metanephrines / nor-metanephrines / VMA and creatinine (for adequacy of collection) and adrenal radiologic imaging (within last 12 months.)

**Indicate test results on this form and fax it with the Endocrinology master referral form if the results are not available in CLIQ. Send a copy of the results with the patient.** Please have the patient bring the Adrenal Radiology Imaging studies to their appointment if they are not available at LIH.

Patient Name: \_\_\_\_\_ Date of Referral: \_\_\_/\_\_\_/\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ LIH Medical Record Number: \_\_\_\_\_

	Result:	Lab Range:	Date:
24 hour urine			___/___/___
Cortisol	_____	_____ - _____	
Creatinine	_____	_____ - _____	
Volume	_____	_____ - _____	
Serum cortisol (Dex. suppressed)	_____	_____ - _____	___/___/___
24 hour urine:			___/___/___
Catecholamines	_____	_____ - _____	
Metanephrines:	_____	_____ - _____	
Nor-metanephrines	_____	_____ - _____	
VMA	_____	_____ - _____	
Creatinine	_____	_____ - _____	
Urine volume	_____	_____ - _____	
Serum Renin	_____	_____ - _____	___/___/___
Serum Aldosterone	_____	_____ - _____	___/___/___
Serum BMP:			___/___/___
Sodium	_____	_____ - _____	
Potassium	_____	_____ - _____	
Chloride	_____	_____ - _____	
CO2	_____	_____ - _____	
BUN	_____	_____ - _____	
Creatinine	_____	_____ - _____	
Glucose	_____	_____ - _____	