

Endocrinology Clinic

Fax: 504.903.1605

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

Patient Label/Stamp

Appendix: MALE REPRODUCTIVE DISORDERS

1. **Hypogonadism, Erectile Dysfunction/impotence with low testosterone levels:** serum FSH, LH, cortisol (8 am), testosterone, ferritin, and prolactin levels (current within 6 months) are required for this referral.

2. **Gynecomastia:** serum FSH, LH, testosterone, prolactin, estradiol, β -HCG, TSH and free T4, liver function tests, and Basic Metabolic Profile (current within the past 6 months) are required for this referral.

Please indicate test results on this form or fax a copy of results with the Endocrine Clinic Referral Form if the results are not available in CLIQ. Please have the patient bring copies of the test results and the MR Imaging studies to their appointment if they are not available at MCL.

If label/stamp is not available please complete the following:

Patient Name: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/___ LIH Medical Record Number: _____

Test:	Result:	Range:	Date:
β -HCG	_____	___ - ___	___/___/___
Serum Cortisol (8 am)	_____	___ - ___	___/___/___
Serum Estradiol	_____	___ - ___	___/___/___
Serum FSH	_____	___ - ___	___/___/___
Serum LH	_____	___ - ___	___/___/___
Serum Prolactin	_____	___ - ___	___/___/___
Serum Testosterone (8 am)	_____	___ - ___	___/___/___
Serum TSH	_____	___ - ___	___/___/___
Serum T4 Free	_____	___ - ___	___/___/___
Liver Profile:			___/___/___

Serum Alkaline phosphatase	_____	___ - ___	
Serum ALT	_____	___ - ___	
Serum AST	_____	___ - ___	
Serum Bilirubin (total)	_____	___ - ___	
Serum Gamma GT	_____	___ - ___	

Serum BMP:			___/___/___
Sodium	_____	___ - ___	
Potassium	_____	___ - ___	
Chloride	_____	___ - ___	
CO2	_____	___ - ___	
BUN	_____	___ - ___	
Creatinine	_____	___ - ___	
Glucose	_____	___ - ___	

*****Please instruct the patient to bring current medications to the clinic for their appointment.**