

C-ENDO DIABETES & ENDOCRINOLOGY CLINIC REFERRAL FORM

PATIENT INFORMATION (attach patient label)

Patient Name: _____ M F
 ULI: _____ DOB: _____
 Address: _____ Postal Code: _____
 City, Province: _____ Home phone: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____
 Practice ID: _____
 Clinic Name: _____
 Clinic Address: _____
 Ph: _____ Fax: _____

Relevant History:

Please Note: We will fax the appointment date and time to your office and notify the patient by phone or letter. The patient may require labs to be completed prior to this appointment and a lab requisition will also be sent to the patient. We require 72-hour notice for cancellation or rescheduling of appointment.

Urgent
 Reason for Urgency:

For triage of referrals please select from the following:

GENERAL ENDOCRINOLOGY

- Adrenal
- Bariatric Matters / Obesity
- Calcium / Parathyroid
- Diabetes Management
- Dyslipidemia
- Hypertension
- Osteoporosis
- Pituitary
- Reproductive - Female
- Reproductive - Male
- Thyroid Disorder
- Other

C-endo proudly serves your patients' needs by our multi-disciplinary team including Endocrinology, Internal Medicine, Pharmacists and Certified Diabetes Educators

Referring Physician Signature: _____
 Date of Referral: _____

C-endo Clinic - A centre of excellence committed to comprehensive diabetes and endocrinology care