WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Referral Form for Endocrinology Program

Telephone: 416-323-6013 Fax: 416-323-6534

Date: _____/_____/_____
YYYY / MM / DD

PATIENT IDENTIFICATION

Referring Physician: _____
Billing Number: _____
Telephone:_____ Fax: _____

Refer to first available physician ☐
Or specify physician _____

Is the patient pregnant? ☐ Yes ☐ No If Yes how many weeks?_____

Reason for Referral

☐ **Diabetes/Tridec** - you must provide results of the following:

Hemoglobin A1C _____ Fasting Blood Sugar _____

☐ Type I ☐ Type II, Duration:_____

Severe Hypoglycemic events? ☐ Yes ☐ No

Do you need: ☐ Endocrinologist Consult, ☐ Allied Health Professional

Specify:_____

☐ **Thyroid** - you must provide results of the following:

☐ Nodule Size_____ (attach report)

☐ Hyper ☐ Hypo TSH_____ (attach report)

☐ **PCOS** (polycystic ovary syndrome) Infertility ☐ Yes ☐ No

☐ **Other Endocrinology** Specify _____

Please notify your patient

Appointment Date: _____/____/_____ Time: _____ at 76 Grenville Street, 4th Floor, Toronto, ON M5S 1B2
YYYY / MM / DD

MD/other: _____

Although we have provided an appointment, the Endocrinologist will triage this referral and your patient may be seen sooner.

We require 2 business days notice for cancellations, failure to do so may result in a fee

Physician Name: _____ Physician Signature: _____
Print