



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/Tridac - 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

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