ENDOCRINOLOGY

DIABETES & METABOLIC DISORDERS

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New Patient Referral Request Form

Please note that an Endocrinology referral coordinator will be contacting the patient directly 24-48 hours after receiving referral.

Please complete patient information below. Attach patient demographic information before faxing.

Today's Date:_____ DOB: _____ ☐ Male ☐ Female ☐ Transgender

Patient Name: Last _____ **First** _____ **MI** _____

Address: _____ City, ST: _____ Zip: _____

Home#: _____ Work#: _____ SSN: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Language assistance needed: ☐ No ☐ Yes Specify Language: _____

Referring Provider: _____ Office Phone: _____

Contact Name: _____ Office Fax: _____

Address: _____

Email Address: _____

Primary Care Provider (if different from above): _____

Office Phone: _____ Office Fax: _____

Lab:

TSH: _____ Free T4: _____ HgbA1c: _____ CBC: _____ Renal Panel: _____

Radiology: _____

_____

Before faxing this referral form, please check the following information which is included so that we may process your referral in a timely fashion.

☐ Pertinent office notes (most recent) ☐ Medication List (necessary) ☐ Additional pertinent testing information

☐ Labs ☐ X-ray reports ☐ Insurance referral

IN ASSOCIATION WITH TNG