

# 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.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pertinent office notes (most recent) | <input type="checkbox"/> Medication List (necessary) | <input type="checkbox"/> Additional pertinent testing information |
| <input type="checkbox"/> Labs                                 | <input type="checkbox"/> X-ray reports               | <input type="checkbox"/> Insurance referral                       |