

PHYSICIAN REFERRAL

Patient Name: _____ Parent Name: _____ Insurance: _____ Insurance ID#: _____ DOB: _____	Daytime Phone: _____ Evening Phone: _____ Address: _____ _____ Height: _____ Weight: _____
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**ENDOCRINE CONSULTATION**

**Diabetes:**  Type 1  Type 2 \_\_\_\_\_ Onset date: \_\_\_\_\_

**Growth:** \_\_\_\_\_

**Thyroid:** \_\_\_\_\_

**Puberty:** \_\_\_\_\_

**Obesity:**

Exogenous obesity related to excessive caloric intake/sedentary lifestyle: Use *Energize!* Program screen and referral form.

Metabolic syndrome: Use *Energize!* Program screen and referral form.

Suspected endocrine obesity: Cushing's disease, hypothyroidism (central or primary), and genetic obesity.

**Insulin resistance**

Metabolic syndrome/acanthosis nigricans/impaired glucose tolerance (2-hour OGTT 140-199)/Impaired fasting glucose (FBG 100-125): Use *Energize!* Program screen and referral.

**Hypercholesterolemia**

Referral criteria:

-Age < 10 years and LDL  $\geq$ 250

-Age > 10 years and LDL  $\geq$  160

-Age > 10 years and triglycerides 300-500 and HDL <35

-Any age and triglycerides  $\geq$  500

Patient meets parameters: Initiate endocrine consultation

Patient does not meet parameters: Use *Energize!* Program screen and referral

**Other:** \_\_\_\_\_

**We need the following information to process this referral:**

\*Growth charts (height and weight)

\*Lab results pertaining to diagnosis or reason for endocrine consultation

\*Demographic information (if not completed above)

We will process this referral, including contacting the parent to schedule appointment, as soon as the complete information is received.

Referring Physician Signature \_\_\_\_\_ Practice \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_