Children's Hospital of Wisconsin®

A member of Children's Hospital and Health System.

Endocrine Consultation Referral Form

Phone: (414) 266-6750 Fax: (414) 266-6749

If your patient has an urgent endocrine problem or is <1 month of age, please call (414) 266-6750. Press option #4 to speak directly with a pediatric endocrinologist.

Thank you for referring your patient. All of our referrals are physician reviewed. Please provide the requested information so that we can schedule your patient quickly and with the appropriate provider.

Your office will be notified by fax when your patient has been scheduled.

☐ **Please check here if you want a provider to call you to discuss the patient prior to sending the medical records. What is the best day and time to reach you?** _____

Patient information

Patient Name: _____

Parent/Guardian Name(s): _____

Date of Birth: ____ /____ /____ **Home Phone:** ____-____-_____

Work Phone: ____-____-____ **Cell Phone:** ____-____-_____

Referring Provider Information

Name: _____

Phone Number: _____-_____-_____

Fax Number: _____-_____-_____

Please let us know why you are requesting an endocrinology consult:

_____

_____

Please provide any of the following information that you have for this patient:

☐ **GROWTH CHARTS**
☐ **OFFICE NOTES AND/OR CLINICAL SUMMARY**
☐ laboratory results
☐ radiology results
☐ any other pertinent information

Referring Provider Signature: _____ Date: _____ /_____ /_____

Please note: The Endocrine Clinic does not have a weight reduction program or a nutritional support program for failure to thrive. If you are unsure about which subspecialty service would best meet your patient's needs the Endocrine office would be happy to assist you. Please contact us at (414) 266-6750, press option #4.

Please fax this completed form to (414) 266-6749

OFFICE USE ONLY Date received: _____ /_____ /_____ Reviewing MD: _____

Date of Appointment _____ /_____ /_____ at _____:_____ with: _____

Diagnosis: _____

☐ Referring physician contacted by Dr. _____ on ____ /____ /____

Comments: _____

_____

Family contacted on: _____/_____/_____ by _____

Special Needs: ☐ Interpreter ☐ Food Diary ☐ Dietitian Appt ☐ Other _____