MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

ENDOCRINOLOGY CLINIC REFERRAL FORM

TEL: (416) 469-6031 FAX: (416) 469-6458

Patient ID Label

Date: ☐ **Routine** ☐ **Urgent**

Patient Last Name:	Given Name: ☐ M ☐ F		Date of Birth: (DD / MMM / YYYY)
Address:		Apt#:	Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Alternate Number: ( )
Contact Person (Caregiver/Parent/Guardian):		Relationship To Patient:	Telephone Number - Contact Person: ( )
Family Physician:	**Ontario Health Card Number:** Version Code		**Email Address For Virtual Consult:**

Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:

PRIVACY: If we call the patient, can we leave a voice message? ☐No ☐Yes
WSIB: Is this treatment due to a work related injury? ☐No ☐Yes
American Sign Language interpreter required? ☐No ☐Yes
Language interpreter required? - specify: ☐No ☐Yes

Referred To:

☐ **First Available Appointment** (within 14 days)
Or specify a physician:_____

Referral Date:

Reason For Referral:

IMPORTANT!

Please send all pertinent lab reports & diagnostic test reports.

If you have scheduled any diagnostic tests, please record the date of the appointment.

Reasons for Referral:

☐ Diabetes
- ○ Type 1
- ○ Type 2

Hemoglobin A1C _____
☐ Diabetes Walking Clinic

☐ Other Endocrinology
Specify:_____

Severe Hypoglycemic events?
☐ Yes ☐ No

Intensive Diabetes Education Needs?
☐ Yes ☐ No

☐ Female reproductive conditions
- ☐ PCOS (Polycystic Ovary Syndrome)

Infertility
☐ Yes ☐ No

☐ Other Female Reproductive
Specify:_____

Other important information:
Is patient pregnant?
☐ Yes ☐ No
Gestational Age:_____ Weeks

Is there a concern of adrenal insufficiency?
☐ Yes ☐ No

Note: Referrals for **Gestational Diabetes or Thyroid** nodules or suspected cancer should be sent to the Diabetes and Pregnancy Clinic and the Thyroid Diagnostic and Assessment Unit respectively.

Investigations To Date:
☐ Ultrasound ☐ Lab Tests ☐ Pathology Reports ☐ Procedures Notes ☐ Consultation Notes
☐ Other Tests:

Past Medical History:

Medications	Name	Dose	Frequency

Referring Physician:

Physician Name:	Physician email:
Telephone Number: ( )	Fax Number: ( )
Physician's Signature:	Billing#:

MGH Appointment Information:

Ocean by CognisantMD
Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

ENDOCRINOLOGY CLINIC REFERRAL FORM
TEL: (416) 469-6031 FAX: (416) 469-6458

Patient ID Label

Date:

☐ **Routine** ☐ **Urgent**