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

REF

Patient ID Label

☐ **Routine** ☐ **Urgent**

Date:

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** Or specify a physician:_____	**Referral Date:**

Reason For Referral:

IMPORTANT!

Please send all pertinent lab reports & diagnostic test reports.

If you have scheduled an diagnostic test, 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 Gestational Age:_____Weeks
☐ No

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:

Medication Name	Dose	Frequency

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

MGH Appointment Information:	

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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**