

Thank you for trusting us with the care of your patients. To help us provide the best possible care, we ask that referrals include **all necessary information**. Submissions missing key details may be returned, which can create delays. Your collaboration ensures we can manage referrals efficiently and give your patients the attention they deserve. We sincerely appreciate your partnership in their care.

1. PATIENT INFORMATION

Name: _____ DOB: _____
Sex: Male ☐ Female ☐ Other _____
Phone: _____
Insurance: _____

2. REFERRING PROVIDER

Provider Name: _____
Person submitting referral: _____
Clinic Name: _____
Phone: _____
Fax: _____

3. REASON FOR REFERRAL & CONDITION-SPECIFIC INFORMATION

Required documents for referral: Referral order, pertinent chart notes, current medication list, labs, imaging (Please include values from the last 6 months)

Referring Diagnosis: _____

- ☐ **Diabetes:** ☐ HbA1c _____
- ☐ **Thyroid:** ☐ TSH _____ ☐ Ultrasound (if thyroid nodules) ☐ Pathology (if Thyroid cancer)
- ☐ **Adrenal / ☐ Pituitary:** ☐ Relevant Labs ☐ Relevant Imaging
- ☐ **Osteoporosis:** ☐ DEXA (required) ☐ CMP/BMP _____
- ☐ **Hypogonadism:** ☐ Testosterone _____
- ☐ **Miscellaneous:** ☐ Relevant Labs ☐ Relevant Imaging

4. ADDITIONAL NOTES AND/OR CLINICAL QUESTION

Failure to provide all documentation will result in a declined referral