CHOC Children's Specialists

Division of Endocrinology Referral Request

Division Phone: 714.509.8634 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Endocrinology.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance : _____ Parent Cell: _____

1. Is this an **URGENT** Endocrine referral (including new onset diabetes)? ☐ No ☐ Yes **If yes, requires a phone call from an MD or RN with clinical information to 714.509.8634**

2. What is the reason you are referring this patient to Endocrinology?:

_____

_____

_____

3. What is the key question you want us to answer?_____

_____

_____

4. Please select one of the following clinics:

☐ **General Endocrinology**	Includes but not limited to: thyroid, puberty, adrenal or calcium disorders
☐ **Growth clinic**	MUST HAVE GROWH CHART AND PARENT'S HEIGHTS: **Mom** ____inches **Dad** ___ inches
☐ **Diabetes clinic**	Includes but not limited to: Previous diagnosis of type 1diabetes, type 2 diabetes or impaired glucose tolerance- Excludes exogenous obesity not likely Endocrine related.

To expedite appointment scheduling, please provide the following by FAX 855-246-2329:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint**
- ☐ **Growth chart, including parent heights.**
- ☐ **Pertinent laboratory results - see referral guidelines for details** http://specialists.chocchildrens.org/referrals
- ☐ **Radiology reports including bone age x-ray.**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax: _____

Provider Address: _____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____

Updated on 8/1/2013