

BCCH ENDOCRINE CLINIC REFERRAL FORM

- Please use Diabetes and Gender referral forms, as applicable (on our website and Pathways)
- PLEASE PAGE OUR ENDOCRINOLOGIST-ON-CALL AT 604-875-2161 FOR NEW-ONSET DIABETES OR LIFE-THREATENING ENDOCRINE CONDITIONS!

Referral to: Dr. _____ or to Endocrinologist-on-call

Referring MD: _____ MSP# _____

MD phone: _____ MD fax: _____

Patient's first name: _____ Patient's last name: _____

Date of birth: _____ (YYYY/MM/DD) Sex: Male Female Other Transgender

PHN: _____ Date of referral: _____ (YYYY/MM/DD)

Parent/guardian name(s): _____

Patient address: _____

Home phone: _____ Cell phone: _____

Interpreter required? Yes No. If 'yes', for which language: _____

PLEASE INCLUDE THE FOLLOWING INFORMATION SO THAT YOUR PATIENT CAN BE TRIAGED APPROPRIATELY, OTHERWISE REFERRAL WILL LIKELY BE DECLINED, AND YOU WILL BE ASKED TO RE-REFER

- Growth chart (if you are not the primary doctor for this patient, please ask GP/Peds to send)
- Physical exam (include tanner staging if puberty referral)
- Relevant labs
 - Short stature: CBC, TSH, free T4, tTG, electrolytes, BUN/Cr, CRP/ESR, IGF-1
 - Puberty: LH, FSH and estradiol or testosterone (ideally drawn 7-8am), +/- DHEAS
- Relevant imaging reports
 - Bone age required if referral for short stature and ≥ 5 years-old

Reason for referral: