Print Form

ENDOCRINOLOGY & DIABETES PROGRAM

Phone: _____ **Fax:** _____

Endocrinologist: _____ **Nurse:** _____

COMMUNITY HEALTH NURSE REFERRAL FORM
FOR CHILDREN WHO ARE CORTISOL-DEPENDENT

Name: _____ Date of Birth: _____

Address: _____ PHN: _____

_____ Home Phone: _____

Parents'/Guardian's Names: _____

School Name: _____ School Phone: _____

Address: _____

Diagnosis: _____

Reason for Referral: to provide education and safety planning for student related to cortisol replacement, e.g. recognize illness or severe injury; contact family and, if needed; utilize 911 and ambulance for hospital transfer; and replace cortisol as directed.

Relevant Medical / Social History: _____

_____

Family Doctor: _____ Phone: _____

Pediatrician: _____ Phone: _____

Doctor Signature: _____

Please note that the following handouts are available on our website: *Outreach Management of Hydrocortisone Replacement* and *Outreach School Letter for the Cortisol-Dependent Student.*