ENDOCRINOLOGY & DIABETES UNIT
Endocrinology Clinic: 604-875-2117
Diabetes Clinic: 604-875-2868
Toll-free Phone: 1-888-300-3088, x2117 or x2868
Fax: 604-875-3231
http://endodiab.bcchildrens.ca

BCCH ENDOCRINE CLINIC REFERRAL FORM

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(s)/guardian's name(s): _____

Patient address:_____

Home phone: _____ Work phone: _____

Cell phone: _____ Interpreter/language? _____

IMPORTANT: Please be sure to include a growth chart and all pertinent labs with your referral. The referral will be prioritized by the Endocrinologist, and the family will be contacted directly with the appointment time. Missing information will delay our ability to schedule an appointment for this patient.

Reason for referral: