U.W.O. DEPARTMENT OF MEDICINE
DIVISION OF
ENDOCRINOLOGY AND METABOLISM

London Health Sciences Centre

St JOSEPH's HEALTH CARE LONDON

OUTPATIENT DIABETES & ENDOCRINOLOGY REFERRAL FORM

Please check the appropriate box.
Copies of this form available at: http://lhdomws.lhsc.on.ca/dom/divisions/endo/refer.htm
or http://www.sjhc.london.on.ca/diabetes-and-endocrinology-and-diabetes-education-centre/referrals

☐ Dr. Lisa-Ann Fraser	519-646-6245	FAX: 519-646-6067	☐ Dr. Ruth McManus	519-646-6371	FAX: 519-646-6372
☐ Dr. Rob Hegele	519-931-5774	FAX: 519-931-5218	☐ Dr. Deric Morrison	519-646-6296	FAX: 519-646-6372
☐ Dr. Irene Hramiak	519-646-6353	FAX: 519-646-6059	☐ Dr. Terri Paul	519-646-6245	FAX: 519-646-6067
☐ Dr. Tisha Joy	519-646-6296	FAX: 519-646-6372	☐ Dr. Tamara Spaic	519-646-6370	FAX: 519-646-6109
☐ Dr. Selina Liu	519-646-6370	FAX: 519-646-6109	☐ Dr. Stan van Uum	519-646-6170	FAX: 519-646-6058
☐ Dr. Jeff Mahon	519-646-6335	FAX: 519-646-6331			
☐ Dr. Charlotte McDonald	519-646-6170	FAX: 519-646-6058	☐ URGENT ENDO CONSULTANT ON-CALL (see criteria below)		

Please complete all sections of this form (URGENT section only if indicated). You will be notified of the appointment (except for URGENT referrals, in which case we may contact the patient directly, due to time limitations).

Patient details

Surname:_____ Given names:_____ _____
Date of birth:_____ Sex: Male ☐ Female ☐
Address: _____
_____
Preferred contact number: Mobile*_____ (2) Other _____
Health card #:_____ VC_____ Other province?_____
Language spoken at home:_____ Interpreter required: Yes ☐ No ☐

Clinical details

Reason for referral / diagnosis:_____
Relevant history/medications:_____
_____
_____
_____
Other problems: _____
_____
_____
_____

Please attach any relevant laboratory, pathology, and imaging results.

URGENT ENDO CONSULTANT ON-CALL REFERRAL – please justify:

- ☐ Newly diagnosed adult with Type 1 diabetes mellitus for insulin start, not requiring admission for diabetic ketoacidosis
- ☐ New onset hyperthyroidism with symptoms
- ☐ Acutely decompensated Type 2 diabetes mellitus with evidence of symptoms and/or metabolic decompensation, i.e. weight loss requiring insulin start
- ☐ Other: please describe and justify _____
_____
_____

Referring physician details

Surname:_____ Given name:_____
Physician number:_____
Address:_____
Telephone number:_____ Fax number:_____

Doctor's signature:_____ Date:_____

Office use only
Date received _____ Clinic _____
Patient notified _____ Referring physician notified _____