OUTPATIENT DIABETES & ENDOCRINOLOGY REFERRAL FORM

Copies of this form available at: https://www.sjhc.london.on.ca/diabetes-and-endocrinology-and-diabetes-education-centre/referral-forms

PLEASE CHECK THE APPROPRIATE BOX

☐ Dr. Kristin Clemens	519-646-6316	FAX: 519-646-6212	☐ Dr. Ruth McManus	519-646-6371	FAX: 519-646-6372
☐ Dr. Rob Hegele (at LHSC)	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 (complete 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 _____ Other _____

Health card #: _____ Version Code _____ 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 names: _____

Physician number: _____

Address: _____

Telephone number: _____ Fax number: _____

Doctor's signature: _____ Date: _____

FOR OFFICE USE ONLY

Date received _____ Appointment with _____ Appointment date _____

Appointment time _____ Patient notified _____ Referring physician notified _____