

PHYSICIAN REFERRAL

Patient Name: _____	Daytime Phone: _____
Parent Name: _____	Evening Phone: _____
Insurance: _____	Address: _____
Insurance ID#: _____	_____
DOB: _____	Height: _____ Weight: _____

ENDOCRINE CONSULTATION

Diabetes: Type 1 Type 2 _____ Onset date: _____

Growth: _____

Thyroid: _____

Puberty: _____

Obesity:

Exogenous obesity related to excessive caloric intake/sedentary lifestyle: Use *Energize!* Program screen and referral form.

Metabolic syndrome: Use *Energize!* Program screen and referral form.

Suspected endocrine obesity: Cushing's disease, hypothyroidism (central or primary), and genetic obesity.

Insulin resistance

Metabolic syndrome/acanthosis nigricans/impaired glucose tolerance (2-hour OGTT 140-199)/Impaired fasting glucose (FBG 100-125): Use *Energize!* Program screen and referral.

Hypercholesterolemia

Referral criteria:

- Age < 10 years and LDL \geq 250
- Age > 10 years and LDL \geq 160
- Age > 10 years and triglycerides 300-500 and HDL <35
- Any age and triglycerides \geq 500

Patient meets parameters: Initiate endocrine consultation

Patient does not meet parameters: Use *Energize!* Program screen and referral

Other: _____

We need the following information to process this referral:

*Growth charts (height and weight)

*Lab results pertaining to diagnosis or reason for endocrine consultation

*Demographic information (if not completed above)

We will process this referral, including contacting the parent to schedule appointment, as soon as the complete information is received.

Referring Physician Signature _____ Practice _____

Physician Name _____ Phone _____ Fax _____