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MetabolicLeader

Endocrinology/Diabetes/Lipid Clinic Referral Form

Date Submitted: _____

Patient's Full Name: _____ Gender: Male OR Female

Date of Birth: _____ SSN: _____ Email:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Tel: _____ Work Tel: _____ Cell: _____

☐ Hearing or Language Interpreter Required ☐ Wheelchair Bound ☐ O2 ☐ Other _____

Please send a copy (front and back) of the patient's Insurance card(s) with referral information.

Insurance Company: _____ Primary Policy Holder:_____

Policy Holder's DOB:_____Certificate #: _____ ____Group #:_____

Insurance Referral Authorization Required? Yes OR No

Referral Auth #: _____ # Visits Allocated: _____ Date Span: _____ to _____

Circle One: Consultation Only OR Consultation with Treatment OR Co-Management

Clear Diagnosis (Description): _____ ICD9 Code:_____

Appointment Urgency: ☐ Urgent (Within 24-48 hours) ☐ Within 1 week ☐ Non-Urgent (Next Available)

Referring Physician: _____ NPI#: _____

Practice Name:_____

Contact Person: _____Contact's Direct Phone Number:_____

Address: _____

Telephone: _____ Fax: _____

Primary Care Physician (if different):_____

Please include the following pertaining to this diagnosis:

For All Endocrinology/Diabetes/Lipid Clinic Referrals

____ Office Note(s) pertaining to the diagnosis
____ Medication List
____ Problem List
____ Lab Results/Flow Sheets
____ Radiology Reports
____ Other

Additional Info for Lipid Referrals Only

____ 1 Year Lipid Profiles
____ TSH
____ CMP