LMC DIABETES & ENDOCRINOLOGY

OTN Patient Referral Form

○ Farsi-speaking ○ French-speaking ○ Greek-speaking ○ Italian-speaking

PATIENT INFORMATION:

Name: (first name) (last name) **DOB:** (dd/mm/yyyy)

Health Card: **Version Code:** **Uninsured Specify:**

Address: (number) (street name) (unit)

(city) (postal code) (e-mail address)

(home #) (work # with extension) (other #)

DIABETES/ENDOCRINOLOGY PLEASE SPECIFY:	**The following investigations would be helpful:**
○ Diabetes ○ Type 1 ○ Type 2 ○ GDM	○ FPG, A1C, Lipids, Renal Function, uACR
○ Thyroid	○ Thyroid function, Relevant imaging
○ Osteoporosis	○ BMD report <2 years, other relevant labs
○ Lipids	○ TC, LDL, HDL (<3 months), A1C
○ PCOS	○ LH, FSH, estrogen, testosterone, A1C
○ Other (please specify):	

Notes: **Current Medications:**

Referred By: **Referring Physician Billing #:**

Referring Physician Signature:

Location: **Patient Preferred Site:**

New Patient Referrals: T: 1.866.701.ENDO (3636) x450 F: 1.877.LMC.APPT (562.2778)
E: referrals@lmc.ca W: www.LMC.ca/referrals