LMC | DIABETES & ENDOCRINOLOGY

Patient Referral Form

☐ **Barrie** ☐ **Bayview** ☐ **Brampton** ☐ **Etobicoke** ☐ **Markham** ☐ **Oakville** ☐ **Thornhill**

PATIENT INFORMATION: **ALL DEMOGRAPHICS REQUIRED**

Name: **D.O.B.** (dd/mm/yyyy)

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

Address:

(number) (street name) (unit)

(city) (postal code) (email)

(home #) (work #) (other#)

PLEASE SPECIFY:		**THE FOLLOWING IS REQUIRED TO BOOK AN APPOINTMENT:**
☐ Diabetes	☐ Type 1 ☐ Type 2 Date of Dx: _____ (dd/mm/yyyy)	• FPG, A1c, Lipids, Renal function (< 3 months)
☐ Diabetes Triage	☐ New diagnosis (appt in 1-2 wks) ☐ Insulin Start ☐ Insulin Pump - Type 1 Ontario ADP Program ☐ Diabetes Education	• FPG, A1c, Lipids, Renal function (< 3 months)
☐ Thyroid		• Thyroid function, relevant imaging (< 3 months)
☐ Osteoporosis		• BMD report < 2 years, other relevant labs
☐ Lipids		• FSH, LH / Ultrasound report, other relevant labs
☐ Other Endocrinology	• Diagnosis:	• Relevant labs
Clinical Notes:		

CURRENT MEDICATIONS:

REFERRED BY: **(Full Name & Address or Stamp)**

Referring Physician Number:

Referring Physician Signature:

Date:

central booking: **T:** 866.701.ENDO (3636) x 450 **F:** 1.877.LMC.APPT (562.2778)
E: referrals@lmc.ca **W:** www.LMC.ca