Joslin Diabetes Center
New Patient Referral Form

Patient Name: _____ DOB: _____

REASON FOR CONSULT
PLEASE CHECK ONE OR MORE OF THE FOLLOWING

PANCREAS & CARBOHYDRATE METABOLISM

___ Type 1 Diabetes *NEW ONSET URGENT*
___ Type 1 Diabetes (DM)
___ Type 2 Diabetes
___ Type 2 Diabetes w/ A1C 9% or higher
___ Diabetes after Pancreatectomy
___ Diabetes with Cystic Fibrosis
___ Diabetes with hypoglycemia
___ Diabetes pending transplant
Other: _____

OVARY
___ Polycystic Ovary Syndrome
Other: _____

TESTS
___ Klinefelter's Syndrome
___ Gynecomastia
___ Low Testosterone ***Must have 2 separate fasting morning testosterone values below normal AND LH, FSH and Prolactin labs**
Other: _____

LIPID METABOLISM
___ Hyper-triglycerides
___ Hypercholesterolemia
Other: _____

TRANSGENDER
___ Male to Female
___ Female to Male
Other: _____

ADRENAL
___ Hyponatremia
___ Adrenal Insufficiency
___ Hypokalemia
___ Adrenal Mass
___ Cushings Syndrome
Other: _____

PARATHYROID & BONE
___ Hypercalcemia
___ Hypocalcemia
___ Hyperparathyroidism
___ Hypoparathyroidism
___ Osteoporosis ***MUST SEND RECENT DEXA SCAN***
Other: _____

HYPOTHALAMUS & PITUITARY
___ Hypopituitarism
___ Prolactinoma
___ Pituitary Adenoma
___ Diabetes Insipidus
Other: _____

THYROID
___ Nodule ***MUST HAVE ULTRASOUND REPORT***
___ Graves Disease
___ Hypothyroidism
___ Hyperthyroidism
___ Goiter
(__) toxic
(__) non-toxic
___ Cancer
Other: _____

Joslin Diabetes Center
and University Endocrinologists and Osteoporosis Center
3229 East Genesee Street, Syracuse, NY 13214
Tel:315.464.5726 Fax:315.464.1656

NEW PATIENT REFERRAL FORM

PLEASE UNDERSTAND:
APPOINTMENT WILL NOT BE MADE UNTIL ALL INFORMATION IS COMPLETED AND RETURNED

REFERRING MD: _____ PHONE: _____ FAX: _____
PLEASE CHECK ONE:
_____ Cancer ____ New Onset Type 1 Diabetes ____ Osteoporosis Surgical Consult
_____ Urgent Consult _____ Routine Consult w/ return to PCP for care

Specific Doctor Requested? _____

DEMOGRAPHIC INFORMATION

PATIENT NAME: _____ DOB: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ CELL: _____ WORK: _____

SOCIAL SECURITY NUMBER: _____

ICD 10 #: _____

Referral Note:

_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE FAX THE FOLLOWING INFORMATION ALONG WITH THE NEW PATIENT FORM TO:
315-464-1656

- **Most recent: labs/ ultrasounds/ MRI's / dexa scans**
- **Most recent office notes**

********PLEASE NOTE: NO APPOINTMENTS WILL BE MADE UNTIL ALL INFORMATION IS COMPLETED AND RETURNED********