Stanford MEDICINE | Health Care

REFERRAL FORM

Stanford Endocrinology

☐Routine
☐Urgent

Phone: 650-721-1300| Fax: 650-320-9443
Physician Helpline: 866-742-4811

REFERRING PROVIDER INFORMATION:

Referred by (MD, DO, NP, PA): _____ Form completed by: _____
Medical Group: _____ Email: _____
Phone:_____ Fax: _____ NPI: _____
Address: _____ City: _____ Zip:_____
_____

PATIENT INFORMATION (Please provide a copy of patient demographics)

Last Name: _____ First Name: _____
DOB:__/__/____ Phone: _____ Gender: ☐M ☐F
City/ State/ Zip: _____
Needs Interpreter? ☐Y ☐N Language: _____

Referral Information: (To avoid delay, use key below)

Pregnant: ☐Y ☐N
Referral Reason per MD:_____
Thyroid Diagnosis (ICD-10 Code):_____
Date of Thyroid Diagnosis: _____
Physician requested: _____
***If requested Physician is unavailable, can Patient be seen by another provider?** ☐Y ☐N
☐ **Consultation** ☐ **2nd opinion**

Reason for Referral	
☐ **Hyperthyroidism**	☐ **Thyroid Cancer**
☐ **Hypothyroidism**	☐ **Thyroids Nodules**

DOCUMENTATION REQUIRED (Please fax with this form):

Diagnosis	**Required Notes**
Hyperthyroidism	TSH, FT4, TT3 in the last month
Hypothyroidism	TSH, FT4 in the last month
Thyroid nodules	TSH, FT4, latest ultrasound in the last month, FNA result if biopsy was done
Thyroid Cancer	TSH, FT4, Thyroglobulin with Tg Abs, Pathology Reports, Dates of surgery

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