Madison Diabetes & Endocrine Care
a service of MEA Medical Clinics

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Madison, MS 39110

ENDOCRINOLOGY REFERRAL FORM

Patient Name: _____ DOB: ____/____/_____ Gender: _____

Phone: _____ Insurance: _____

Referring Physician: _____ Clinic Number: _____

Reason for Referral (check all that apply):

☐ Type 1 DM ☐ Type 2 DM ☐ Prediabetes ☐ CGM/Pump ☐ Thyroid Disorder ☐ Nodule/Goiter

☐ Hyperthyroid ☐ Hypothyroid ☐ Osteoporosis ☐ Vit D Deficiency ☐ Pituitary ☐ Adrenal

☐ PCOS ☐ Hypogonadism ☐ Obesity ☐ Hyperparathyroidism ☐ Other: _____

Please note: We will perform in-house thyroid ultrasounds and Fine needle aspirations (FNAs).

Primary Diagnosis/ICD-10:

_____

Current Medications:

_____

Attachments: ☐ Labs ☐ Ultrasound ☐ DEXA ☐ CT ☐ MRI ☐ Hospital Records ☐ Office Notes

Please include a demographic sheet, insurance cards, last progress note, recent labs, and studies.

Referral Priority: ☐ Routine ☐ Urgent ☐ STAT Reason for Urgency: _____

Additional Comments: _____