

**Consultation  
Request Form:**

**For Referring Provider:**



**Fill out**

Please complete this required brief provider consultation request form.

**Attach**

Attach pertinent chart notes, lab results, imaging reports and growth charts.

**Fax**

Please fax to 503.418.2208. Clinic staff will contact patient to schedule.

**Please indicate the specialty to which you are referring your patient:**

- General Endocrinology   
  Bone & Mineral   
  Lipid   
  Adult Diabetes   
  Pediatric Diabetes

**Patient Information:**

|  |                                |                                |  |
|--|--------------------------------|--------------------------------|--|
| Name:  |                                | Date of Birth:                 | Sex: M <input type="checkbox"/> F <input type="checkbox"/> |
| Parent/Guardian Name(s):                               |                                | Language if not English:       |  |
| <i>(Please check preferred contact phone numbers:)</i> |                                |                                |  |
| <input type="checkbox"/> Home:                         | <input type="checkbox"/> Cell: | <input type="checkbox"/> Work: |  |
| Address:   |                                |                                |  |

**Medical Issue:**

REQUIRED Question for Consultation:

|  |       |
|--|-------|
| Diagnosis:   | ICD9: |
| <input type="checkbox"/> <b>Routine:</b> Next available appointment <input type="checkbox"/> <b>Semi-Urgent:</b> Two weeks or less <input type="checkbox"/> <b>Emergent:</b> One day to one week |       |
| *If Emergent or Semi-Urgent, please specify a reason:  |       |

Requesting evaluation by: \_\_\_\_\_ (If requesting specific endocrinologist)

Request for:     One time visit     Ongoing Evaluation and Treatment

Attach recent lab values specific to Endocrinology/Diabetes/Lipid consult: (ie. thyroid panels, lipid panels, glucose, HgA1C, Vitamin D)  
 Attach imaging studies and other reports (ie DEXA, CT and Ultrasound)

**Insurance Information**

|   |  |
|---|--|
| Insurance carrier name:   | Phone Number:                                    |
| Policy number:  | Group Number:                                    |
| Is pre-authorization required for service? <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, please provide the authorization number: |
| Authorized number of visits:  | Date Span:                                       |

**Referring Provider Information:**

|  |
|--|
| Provider:                                    |
| Address:                                     |
|  |
| Phone:                                       |
| Fax:   |
| PCP (if different than referring Physician): |

**Harold Schnitzer Diabetes Health Center  
Adult Endocrinology & Clinical Nutrition:**

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 Fax: 503.418.2208