Endocrine Practice Group

Strong Memorial Hospital
601 Elmwood Ave. Box 693
Rochester, NY 14642
Phone: 585-275-2901 Fax: 585-273-1288

NEW PATIENT REQUEST FORM

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

REFERRING MD:_____ PHONE:_____ FAX:_____
PLEASE CHECK ONE:
_____ Urgent Consult _____ Routine Consult w/ return to PCP for care _____ Pregnant/Cancer
Specific Doctor Requested? _____
DEMOGRAPHIC INFORMATION

PATIENT NAME: _____ DOB: _____
LAST FIRST MI

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE:_____ CELL: _____ WORK:_____

SOCIAL SECURITY NUMBER: _____

INSURANCE CARRIER: _____

POLICY #: _____ REFERRAL #: _____

Referral Note (Optional):

_____
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FOR ENDOCRINE OFFICE USE ONLY:

Received from Ref. Doctor:_____Sent to Dr._____ For Review on _____
Doctor's Assessment_____ Returned to Scheduling_____
Sent to Fellow_____ Returned from Fellow_____
Appt on _____ @ _____ with _____ MR# _____
Ref. Doctor Notified _____ NPV Letter MTPH _____ Coumadin LTR MTPH_____
Comments: _____

Endocrine Practice Group
New Patient Request Form

PATIENT NAME: _____ DOB: _____

REASON FOR CONSULT

PLEASE CHECK ONE OR MORE OF THE FOLLOWING

PANCREAS & CARBOHYDRATE METABOLISM

____ Type 1 Diabetes (DM)
____ Type 2 Diabetes
(Must have secondary diagnosis)
____ Diabetes out of control
____ Diabetes with frequent hypoglycemia
____ Diabetes with retinopathy
____ Diabetes with neuropathy
____ Diabetes nephropathy
____ Diabetes pending transplant
____ Diabetes with elevated HbA1C
Other: _____

OVARY

___ Amenorrhea
____ Polycystic ovary syndrome
____ Female hypogonadism
Other: _____

TESTIS

____ Klinefelter's Syndrome
____ Gynecomastia
____ Hypofunction
Other _____

OBESITY & LIPID METABOLISM

____ Lipodystophy
____ Hypercholesterolemia
____ Obesity (Morbid / unspecified)
Other: _____

VASCULAR

____ HTN, unspecified
____ Orthostatic hypotension
Other: _____

ADRENAL

___ Hyponatremia
____ Adrenal Insufficiency
____ Hypokalemia
____ 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
____ Hyperthyroidism ____ Hypothyroidism
____ Goiter (____toxic ____non toxic)
Other: _____

PLEASE FAX THE FOLLOWING INFORMATION ALONG WITH THE NEW PATIENT FORM TO **585-273-1288**

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

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