Stanford HEALTH CARE

REFERRAL FORM

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

☐Routine
☐Urgent

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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