ROYAL NORTH SHORE ENDOCRINOLOGY CLINICS

REFERRAL FORM (Please Print)

Date:	**Urgent** - *if urgent, complete and submit this form and contact the Endocrine Registrar/Fellow through switchboard (02 9926 7111) to discuss interim management and facilitate an early appointment.*

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ ______	Patient email address:

RNSH MRN: (if available)	Interpreter Required? ❑ No ❑ Yes – Language:	Birth date:	Age:	Sex: ❑ M ❑ F

Street address:	Medicare no.: DVA no.:

P.O. box:	Suburb:	State:	Postcode:

Home phone no.:	Mobile no.:

Is the patient of Aboriginal or Torres Strait Islander origin?
❑ No ❑ Unknown if Yes: ❑ Aboriginal ❑ Torres Strait Islander

Choose clinic (check one box):		❑ Dr. ______	❑ Endocrine	❑ Thyroid
❑ Diabetes	❑ Young Adult T1DM (18-30y.o.) Clinic	❑ Healthy Weight Clinic	❑ Neuroendocrine	❑ Turner Syndrome Clinic

Reason for referral: (Please refer to the guidelines for referral – click here)
Include or attach all relevant investigations and information to help assist appropriate triage.

Relevant Clinical History and Examination:

Relevant Investigations:	Medications:

Health
Northern Sydney
Local Health District

REFERRING CLINICIAN DETAILS:		
Clinician Name:		Provider number:
Practice Address:		
Phone number:	Fax number:	Email:
Referring clinician signature		*Date*

This referral is for: 3 months 6 months 12 months indefinite referral

Total Pages: ____________

FAX COMPLETED FORM TO (02) 9463 1045

ENDOCRINE DEPARTMENT USE ONLY:				
Date Received:			Triaged by:	
Allocated Clinic:	❑ Dr.	______	❑ Endocrine	❑ Thyroid
❑ Diabetes	❑ Young Adult T1DM (18-30y.o.) Clinic	❑ Healthy Weight Clinic	❑ Neuroendocrine	❑ Turner Syndrome Clinic
❑ Urgent:	❑ Routine:		Comments:	