SHOALS PRIMARY CARE ENDOCRINOLOGY

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PATIENT REFERRAL FORM

Date of Referral: _____

Referring Provider Information
Referring Provider First Name: _____ Referring Provider Last Name: _____
Practice / Clinic Name: _____
City / State: _____
Phone Number: _____ Fax: _____
Office Contact Name (First & Last): _____

Patient Information
First Name: _____ Last Name: _____
Date of Birth (MM/DD/YYYY): _____ Phone Number: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Primary Insurance: _____ Contract #: _____ Group #: _____
Name on Insurance (First & Last): _____ Date of Birth (MM/DD/YYYY): _____

Reason for Referral
⚠ ***Please include copies of all relevant labs, imaging reports, and most recent office note with this referral.***
☐ Diabetes management (Type 1 / Type 2 / Gestational)
☐ Thyroid disorder (hypothyroidism / hyperthyroidism / thyroid nodules / thyroid cancer)
☐ Adrenal disorder ☐ Pituitary disorder
☐ Parathyroid disorder ☐ Osteoporosis / Bone metabolism disorder
☐ Lipid disorder ☐ Other: _____

Urgency
☐ Routine (next available) ☐ Urgent (within 2 weeks) ☐ STAT (within 24–48 hours [please call])

Appointment Policy

It is the policy of Shoals Primary Care – Endocrinology to charge $50.00 to any patient account who fails to show up for a scheduled appointment without providing 2 business days advance notice of cancellation.