UB|MD PEDIATRICS

NEW PATIENT REFERRAL FORM

Please complete the following and fax to the Division of Endocrinology/Diabetes at 716.323.0297.

Patient Name: _____ DOB: _____/_____/_____

Referring Provider: _____

PMD (if different than above): _____

Phone: _____ Fax: _____

Chief Complaint: _____

History (Check any that apply):

- ☐ Abnormal Blood Chemistry
- ☐ Abnormal Thyroid Tests
- ☐ Goiter
- ☐ Hypoglycemia
- ☐ Polydipsia/Polyuria
- ☐ Galactorrhea
- ☐ Vitamin D Deficiency
- ☐ Early Sexual Development
- ☐ Failure to Thrive
- ☐ Obesity
- ☐ Abnormal Weight Gain
- ☐ Elevated Glucose/HbA1c
- ☐ Acanthosis Nigricans
- ☐ Amenorrhea
- ☐ Irregular Menses
- ☐ Polycystic Ovarian Syndrome
- ☐ Short Stature
- ☐ Tall Stature
- ☐ Poor Growth
- ☐ Gynecomastia
- ☐ Small Penis
- ☐ Down Syndrome
- ☐ Hirsutism

- ☐ Axillary Odor/Hair
- ☐ Pubic Hair Development
- ☐ Breast Enlargement
- ☐ Testicular Enlargement
- ☐ Penile Enlargement

Other: _____

Additional Comments:

If you need to reach our office, please call 716.323.0170. Thank you for your referral.

Division of Endocrinology/Diabetes
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