Savannah ENDOCRINOLOGY
ISMARY DE CASTRO, MD

PATIENT REFERRAL FORM

Fax completed form with demographics/insurance information to: (912) 244-6744

Patient Information: ☐ **New Patient** ☐ **Prior Patient/transferring care**

Name:_____DOB:_____

Phone no: _____

Insurance:_____

Referring Physician: _____

Reason for Referral:

Diabetes ○ Type 1 ○ Type 2 ○ GDM ○ DM in pregnancy (rapid triage 1-2 weeks) ○ New onset DM (rapid triage 1-2 weeks) ○ DM education/technology (pump/CGM)	<u>The following labs would be helpful:</u> A1c Lipids Metabolic panel/renal function, UACR
○ Thyroid	Thyroid lab, relevant imaging
○ Osteoporosis ○ Hypercalcemia	DXA scan, metabolic panel, vit D
○ Lipids ○ Metabolic syndrome ○ PCOS	Lipid panel Metabolic panel
○ Pituitary	Relevant Imaging
○ Adrenal	
○ Other (please specify)	

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