Lakshmi Kannan, MD—Endocrinology, Diabetes and Medical Bariatrics
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ENDOCRINOLOGY REFERRAL FORM

Patient's Name: ____

DOB: ____________________ Phone#: ____________________ Cell#: ____________________

Height: ____________________ Weight: ____________________

Address: ____

Patient's Primary Care Physician: ____

Insurance Carrier: ____

Policy #: ____

Referral authorization # if required ____________________

Please include all pertinent clinical documentation such as lab results, imaging, office notes, etc.

REASON FOR REFERRAL (CIRCLE ONE)

ENDOCRINE	**DIABETES MELLITUS**	**MEDICAL WEIGHT LOSS**
Adrenal disease		
Calcium disorder		
Parathyroid disorder		
Osteoporosis		
Thyroid disease		
Polycystic ovarian syndrome		
Pituitary disorder		

Other: ____

Physician: ____

Phone #: ____________________ Fax #: ____________________

Provider Signature: ____________________ Date: ____________________

Appointment Date/Time: ____________________ Patient notified on: ____________________

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

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