Independence Park Medical Services

Dr. Cydney Fenton

Specializing in Pediatric Endocrinology

9500 Independence Dr. #900

Anchorage, AK 99507

Clinic Phone: (907) 522-1341 • Fax: (907) 522-1343

https://www.ipmsak.com/

ENDOCRINOLOGY REFERRAL REQUEST

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ ____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance: _____ Parent Cell: _____

1. Is this an **URGENT** Endocrine referral (including new onset Diabetes, TSH >30, newly diagnosed adrenal insufficiency, or Hyperthyroid with very low TSH) ☐ No ☐ Yes **If yes, requires a phone call from an MD, NP, or PA with clinical information to (907) 522-1341**

2. **What is the reason you are referring this patient to Endocrinology?**

Hypothyroidism	**Hyperthyroidism**	**Goiter**
Type 1 Diabetes	**Type 2 Diabetes**	**Pre-Diabetes**
Irregular menses	**Amenorrhea**	**Abnormal newborn screen**
Adrenal Insufficiency	**Congenital Adrenal Hyperplasia**	
Premature Puberty	**Delayed Puberty**	**Klinefelter's Syndrome**
Short Stature	**Bone Health**	**Turner Syndrome**
Hypopituitarism	**Prader-Willi Syndrome**	**DiGeorge Syndrome**

Other: _____

To expedite appointment scheduling, please provide the following by FAX (907) 522-1343:

- ☐ **This completed form**
- ☐ **Medical records related to the chief complaint** ☐ **Growth chart, including parent heights.**
- ☐ **Pertinent laboratory results**
- ☐ **Radiology reports including bone age x-ray. Please request that a copy of the film be sent to the office as well.**
- ☐ **Authorization, or if not applicable a copy of insurance card**

Referring Provider Name: _____ **Phone:** _____ **Fax:** _____

Provider Address: _____ **City:** _____ **Zip:** _____

Provider Signature: _____ **Date:** _____ **Time:** _____

Thank you for referring your patient to Endocrinology at IPMS.