Dartmouth Health

Dartmouth Hitchcock Clinics

Phone: (603) 645-6401
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for Endocrinology

Specific question to be answered by consult: _____

_____

_____

_____

Labs:

TSH: _____ Free T4: _____ HgbA1c: _____ Testosterone: _____ 25 OH Vit D: _____

Chol: CA: _____ M AG: Ins _____ Ulin: _____ PTH: _____

Radiology: _____

_____

_____

Before faxing this referral form, please check the following information which is included so that we may process your referral in a timely fashion.

❑ Pertinent office notes (necessary) ❑ Medication list (necessary) ❑ Additional pertinent testing information

❑ Labs (if applicable) ❑ X-ray reports ❑ Insurance referral (if required)