

Endocrine Request for Service Order

Pt. Name: _____
 DOB: _____
 MRN (If available): _____
 Parent Name _____
 Phone # _____ Preferred time: 8-12, 12-5, after 5
 Insurance: Medicaid, PPO, HMO, Self-pay / Other

Referring Provider Name: _____
 Practice Name: _____
 Date of Request: _____

Please attach patient's demographics

Step 1: When should patient be seen?

- ASAP (\leq 24 hours)
 - For physicians new to Lurie Children's – Call the VIP Physician Hotline – **800.540.4131, Option 4**
 - For all other physicians, call the Lurie Children's Endocrine Department Directly at **312.227.6090**
- Within 2 weeks
- > 2 weeks

Step 2: Identify Chief Complaint

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Newborn Screen | <input type="checkbox"/> Short Stature | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Neuro/Endocrine Disorder | <input type="checkbox"/> New diagnosis of Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Pituitary lesion & Optic Nerve Hypoplasia | <input type="checkbox"/> Delayed Puberty | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Irregular Menses/Hirsutism | <input type="checkbox"/> Precocious Puberty | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Ambiguous Genitalia | <input type="checkbox"/> Calcium Disorders | <input type="checkbox"/> Nodules/Concern
for or Diagnosed
Neoplasm |
| <input type="checkbox"/> Other: _____ | | |

Step 3: Info Requested for Each Referral

- 1) **Pertinent and Quick Patient History (1 – 2 sentences):** (Please Print)

- 2) **Questions referring provider wants answered by Specialist**

- 3) **Has the referring provider already spoken with a Lurie specialist about this referral?**

- 4) **Is there a preferred provider to see the patient?**

- 5) **Which location is preferred for the patient's appointment?**

Ensure the following are sent to the Specialist (Endocrine Fax 312.227.9403)

- | | |
|---|---|
| 1. Current Medications | 5. Imaging (provide disk if available) |
| 2. Pertinent Labs | 6. Previous Endocrine Results (if available) |
| 3. Growth Chart | 7. Previous Genetics and GI Consults (if available) |
| 4. Bone Age (provide disk if available) | |

Please submit this request to KidsDoc Fax #: 312.227.9832