

Date: _____

OUTPATIENT CONSULT REQUEST



Metabolism, Endocrinology & Diabetes/Podiatry (MEND)

Office: 734-647-5871

Fax: 734-998-1439

Fax Form and Test Results* to:
734-998-1439

Patient Demographic Information

Patient Last Name:		Patient First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Patient Sex assigned at birth:		Patient Gender:	
Main Contact Name (if not patient):		Main Contact Phone:	
Primary Insurance Company:			
Medical Record Number (MRN) or SSN:		Date of Birth:	

Physician Information

Referring Physician Name:			
Office Contact Name:			
Address:	City:	State:	Zip:
	Phone:	Fax:	
Primary Care Physician Name (if different than referring physician):			
Address:	City:	State:	Zip:
	Phone:	Fax:	

Patient pregnancy status: <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Planning pregnancy <input type="checkbox"/> Immediately post-partum <input type="checkbox"/> Not applicable	Status of the primary diagnosis: <input type="checkbox"/> New or untreated/unstable <input type="checkbox"/> Established and stable <input type="checkbox"/> Suspected <input type="checkbox"/> Not Applicable
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*Hard copies of abnormal test results, ultrasounds, CT scans, MRI's that support the suspected diagnosis are required for a patient to be seen.

PRIMARY DIAGNOSIS: Select ONLY 1 primary diagnosis and answer the questions to its right. <input type="checkbox"/> ADRENAL	<input type="checkbox"/> Adrenal cancer / adrenal cortical carcinoma (Refer to Endocrine Oncology Clinic) <input type="checkbox"/> Adrenal Insufficiency (including Addison's disease) <input type="checkbox"/> Adrenal mass / nodule (including bilateral adrenal hyperplasia) <input type="checkbox"/> Carcinoid <input type="checkbox"/> Congenital adrenal hyperplasia <input type="checkbox"/> Cushing's syndrome <input type="checkbox"/> Hyperaldosteronism <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypokalemia <input type="checkbox"/> Multiple endocrine neoplasia <input type="checkbox"/> Neuroendocrine tumor <input type="checkbox"/> Pheochromocytoma / Paranglioma	Do you suspect Cushing's Disease due to a pituitary adenoma? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BONE / CALCIUM	<input type="checkbox"/> Hypercalcemia <input type="checkbox"/> Hyperparathyroidism <input type="checkbox"/> Hypocalcemia <input type="checkbox"/> Hypoparathyroidism <input type="checkbox"/> Kidney stones <input type="checkbox"/> Osteomalacia <input type="checkbox"/> Osteopetrosis <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Paget's Disease of Bone	Patient calcium level: <input type="checkbox"/> < 8.0 mg/dl <input type="checkbox"/> ≥ 11.4 mg/dl <input type="checkbox"/> 8.0 to 11.3 mg/dl

<input type="checkbox"/> FEMALE REPRODUCTIVE	<input type="checkbox"/> Amenorrhea / oligomenorrhea <input type="checkbox"/> Female hypogonadism <input type="checkbox"/> Hirsutism <input type="checkbox"/> Turner's syndrome <input type="checkbox"/> Menopause <input type="checkbox"/> Hair loss in female patient <input type="checkbox"/> Polycystic ovarian syndrome (PCOS)	Is this referral for fertility treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> DIABETES	<input type="checkbox"/> Type 1 diabetes or Latent Autoimmune Diabetes of the Adult (LADA) <input type="checkbox"/> Type 2 diabetes <input type="checkbox"/> Pancreatitis-related diabetes (Type 3c diabetes) <input type="checkbox"/> Pancreatic cancer diabetes (Type 3c diabetes) <input type="checkbox"/> Cystic fibrosis-related diabetes (Type 3c diabetes) <input type="checkbox"/> Atypical diabetes (including Atypical Diabetes Program) <input type="checkbox"/> Lipodystrophy or progeria <input type="checkbox"/> MODY/Maturity Onset Diabetes of the Young <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Diabetes in pregnancy <input type="checkbox"/> Pediatric Diabetes Transition Clinic (18- 22 years)	Does patient have history of pancreatitis, pancreatic cancer, CFRD, hemochromatosis or alcoholism? <input type="checkbox"/> YES <input type="checkbox"/> NO Does patient have history of autoimmune thyroid disease or other autoimmune disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Does patient have recent triglycerides >2000 or a history of acute pancreatitis? <input type="checkbox"/> YES <input type="checkbox"/> NO Patient age at diagnosis: <input type="checkbox"/> 0-24 years old <input type="checkbox"/> 25+ years old Patient A1c level: <input type="checkbox"/> ≤ 10 <input type="checkbox"/> > 10
<input type="checkbox"/> HYPOGLYCEMIA	<input type="checkbox"/> Hypoglycemia	What is the primary contributing factor? <input type="checkbox"/> History of bariatric surgery <input type="checkbox"/> Diabetes/prediabetes <input type="checkbox"/> Known endocrine tumor <input type="checkbox"/> Suspected endocrine tumor <input type="checkbox"/> Unknown
<input type="checkbox"/> MALE REPRODUCTIVE	<input type="checkbox"/> Abnormal genitalia <input type="checkbox"/> Low testosterone <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Klinefelter syndrome <input type="checkbox"/> Male hypogonadism <input type="checkbox"/> Small testes <input type="checkbox"/> Gynecomastia	Does the patient have lab-confirmed low testosterone? <input type="checkbox"/> YES <input type="checkbox"/> NO

<input type="checkbox"/> TRANSGENDER CARE	<input type="checkbox"/> Transgender care	
<input type="checkbox"/> OBESITY AND LIPIDS	<input type="checkbox"/> Obesity <input type="checkbox"/> Obesity syndrome <input type="checkbox"/> Prediabetes <input type="checkbox"/> Metabolic syndrome <input type="checkbox"/> Lipid disorder <input type="checkbox"/> Weight Management Program <input type="checkbox"/> Obesity and Metabolic Disorders Program	<p>Does patient have recent triglycerides >2000 or a history of acute pancreatitis?</p> <input type="checkbox"/> YES <input type="checkbox"/> NO <p>Does patient have possible obesity genetic syndrome?</p> <input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> Post-bariatric surgery follow up Does patient have lap band? <input type="checkbox"/> YES – placed at Michigan Medicine <input type="checkbox"/> YES – placed outside of Michigan Medicine <input type="checkbox"/> NO Did patient have bariatric surgery at Michigan Medicine: <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Does patient have any metabolic complications?</p> <input type="checkbox"/> Bone disease <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Persistent vitamin or metabolism abnormality <input type="checkbox"/> Poorly controlled diabetes (A1c > 8%) <input type="checkbox"/> Weight gain > 30%
<input type="checkbox"/> THYROID	<input type="checkbox"/> Thyroid Nodules – Goiter <p>If your patient's nodule is ≥ 2cm in size, would you like the patient to be considered for any of the following (check all that apply)?</p> <input type="checkbox"/> Intervention such as radiofrequency ablation or surgery for a benign nodule	
	<input type="checkbox"/> Thyroid Cancer – Anaplastic (Refer to Medical Oncology Clinic) <input type="checkbox"/> Thyroid Cancer - Medullary (Refer to Endocrine Oncology Clinic) <input type="checkbox"/> Thyroid Cancer – Papillary or Follicular	<p>Patient has known lymph node or distant metastasis:</p> <input type="checkbox"/> No <input type="checkbox"/> Yes - Please cancel this referral and refer to Endo Oncology

	<input type="checkbox"/> Hyperthyroidism or Graves' Disease <input type="checkbox"/> Hypothyroidism or Hashimoto's	Patient TSH level: <input type="checkbox"/> Normal 0.5-5 <input type="checkbox"/> Abnormal < 0.5 <input type="checkbox"/> Abnormal 5-30 <input type="checkbox"/> Abnormal > 30 Patient T4 level: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<input type="checkbox"/> PITUITARY	<input type="checkbox"/> Acromegaly <input type="checkbox"/> Cushing's Syndrome <input type="checkbox"/> Empty Sella syndrome <input type="checkbox"/> Galactorrhea <input type="checkbox"/> Hyperprolactinemia <input type="checkbox"/> Hypopituitarism <input type="checkbox"/> Pituitary tumor <input type="checkbox"/> Prolactinoma	Does patient have a pituitary tumor? <input type="checkbox"/> YES <input type="checkbox"/> NO Size of Pituitary Tumor <input type="checkbox"/> < = 1 cm <input type="checkbox"/> > 1 cm <input type="checkbox"/> Unknown
	<input type="checkbox"/> Diabetes insipidus <input type="checkbox"/> Hypernatremia <input type="checkbox"/> Hyponatremia <input type="checkbox"/> Syndrome of Inappropriate Antidiuretic Hormone (SIADH)	Patient serum sodium level? <input type="checkbox"/> ≥ 150 <input type="checkbox"/> ≤ 130 <input type="checkbox"/> 131-149
<input type="checkbox"/> OTHER	Please indicate primary reason for referral, if not listed above, or if there are additional diagnoses that should be addressed in this referral:	