The Institute Of Diabetes & Endocrinology

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☐ **Endocrinology** ☐ **Nephrology** ☐ **Internal Medicine**

PATIENT INFORMATION

First Name: _____________ Last Name: ___________________

Health Card #: __________ Version Code: _________ DOB (DD/MM/YYYY)

Contact #: ____________ Address:______________ ___/____/_______

Endocrinology	Nephrology	Internal Medicine
☐ Diabetes ☐ Type 1/☐ Type 2 ☐ Diabetes Education ☐ Thyroid Dysfunction ☐ Thyroid Nodules/ Cancer ☐ Osteoporosis ☐ Dyslipidemia/Cholesterol Ed. ☐ Amenorrhea/ PCOS ☐ Other _______________________ _______________________	☐ Refractory HTN ☐ Renal Insufficiency / CKD ☐ Hematuria ☐ Nephrolithiasis (recurrent) ☐ Glomerulonephritis/ Renal Vasculitis ☐ Proteinuria ☐ Other _______________________ _______________________	☐ Chest pain/CHF/Arrythmia ☐ Complex Elderly ☐ Pre-Op Assessment ☐ Polypharmacy ☐ Recent Hospital Discharge ☐ Bleeding/Clotting Disorders ☐ COPD/ Asthma/ Bronchitis ☐ Other _____________________
☐ URGENT (1-2 WEEKS)	☐ SEMI-URGENT (2-4 WEEKS)	☐ LESS URGENT (4-6 WEEKS)
PREFERRED LOCATION:	☐ **AJAX**	☐ **SCARBOROUGH**

REFERRING PHYSICIAN : ___________________________

BILLING #: ______________ **PHONE:** _______________ **FAX:** _______________