

**UNIVERSITY OF SOUTH FLORIDA
ALL CHILDREN'S HOSPITAL
PEDIATRIC ENDOCRINOLOGY
REFERRAL**

REFERRING PHYSICIAN

NAME _____
ADDRESS _____
TELEPHONE NUMBER _____
FAX NUMBER _____

PARENTS

NAME (S) _____
ADDRESS _____
TELEPHONE NUMBER (S) _____
MOTHER'S HEIGHT _____
FATHER'S HEIGHT _____
RELEVANT FAMILY HISTORY _____

PATIENT

NAME: FIRST, MI, LAST _____
DOB _____
GENDER _____

CHIEF COMPLAINT _____
HISTORY _____
PHYSICAL EXAMINATION
 HEIGHT _____
 WEIGHT _____
 RELEVANT FINDINGS _____
LABORATORY DATA _____

***PROBLEM**

SHORT STATURE
TALL STATURE
SEXUAL PRECOCITY
DELAYED ADOLESCENCE
THYROID DYSFUNCTION
DIABETES MELLITUS

***SUGGESTED PRELIMINARY STUDIES**

BONE AGE
BONE AGE
BONE AGE
BONE AGE
T4, T3RU, TSH, ANTI-TPO, ANTI-TG (as appropriate)
BLOOD GLUCOSE, HgbA1c

FOR OTHER PROBLEMS, PLEASE CALL AND DISCUSS WITH
PEDIATRIC ENDOCRINOLOGIST ON CALL (727 767 2444)

PLEASE FAX TO 727 767 4219:

COMPLETED REFERRAL FORM
PATIENT'S GROWTH CHART
OTHER PERTINENT MATERIAL

(PLEASE INCLUDE AREA CODE WITH TELEPHONE AND FAX NUMBERS)