CAROLINA ENDOCRINE, P.A.
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www.carolinaendocrine.com

Patient Referral Form

Date: _____

# of Pages (Including Cover): _____

**Please include ALL medical records (office notes, labs, radiology, pathology reports, etc.) with this completed referral form*

REQUESTING CONSULTATION WITH:

Michael J. Thomas, M.D. Ph.D., ECNU

☐ Erin Wetherill, PA-C ☐ Megha Karmalkar, PA-C

☐ Aaron Burman, PA-C ☐ No Preference

OFFICE USE:

Appointment Date & Time:

_____

REASON FOR REFERRAL:

☐ Thyroid Nodule or Goiter ***Neck ultrasounds can be performed in our office at time of visit ***

☐ Osteoporosis/Metabolic Bone Disease ☐ Thyroid Dysfunction

☐ Adrenal Disorder ☐ Pituitary Disorder

☐ Endocrine Hypertension ☐ Parathyroid Disorder

☐ Basic Reproductive Endocrinology ☐ Thyroid Cancer

☐ Other: _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Phone Numbers: *Please Check BEST Contact Number:

☐ Home: _____ ☐ Cell: _____

Patient Email (For Portal & Reminders): _____

Insurance Provider (Please provide copy of card): _____

REFERRING PHYSICIAN INFORMATION:

Provider Name: _____ Supervising M.D.: _____

Practice Name: _____

Office Phone: _____ Office Fax: _____

Thank you for choosing Carolina Endocrine, P.A.

We look forward to assisting in the healthcare needs of your patient.

Please feel free to contact our office with any questions or concerns.