BARROW
Neurological Institute

Neuroendocrine Testing

Patient Referral Form

TO BE COMPELTED BY PATIENT'S ENDOCRINOLOGIST

Patient Information

Name: Daytime Phone: Patient Diagnosis: Allergies:	Outside Medical Record #: Date of Birth: ICD-10 Code:

Requested Test

Growth Hormone	Cortisol	AI/DI
❑ Oral Macrilen Stimulation Test	❑ Cortrosyn Stimulation Test (250 mcg)	❑ Insulin Tolerance Test
❑ Glucagon Stimulation Test	❑ Hydrocortisone Day Curve	❑ Water Deprivation Test
❑ Insulin Tolerance Test	❑ DEX/CRH Test	❑ Other/Additional Labs
❑ Oral Glucose Tolerance Test		

Referring Provider Information

Provider Name:	
Practice Name and Address:	
Phone:	Fax:

Once complete, please fax to Neuroendocrine Testing Unit: **(602) 406-2770**
Please have patient call the registration line: **(602) 406-2748**
Include recent chart notes with medical history

Office Use only
Name: Birthdate: Account #: Med. Rec. #: