



Medical Clinic of North Texas
ENDOCRINOLOGY

MCNT.com/SHaq
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ENDOCRINOLOGY

Consultation Referral

Seema Haq, M.D.
Endocrinology

Denton Location
2501 Scripture, Suite 300
Denton, TX 76201
(940) 566-4919
(940) 484-8539 (fax)

Carrollton Location
4360 N. Josey Lane
Carrollton, Texas 75010
(972) 242-0185
(972) 242-5786 (fax)

GENERAL INFORMATION

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Soc. Sec. #: _____

D.O.B.: _____

Weight: _____ Height: _____

Allergies: _____

Sex: Male Female

FROM THE OFFICE OF:

Physician Name: _____

Practice Name/Hospital: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

State Lic. #: _____ DEA #: _____

NPI #: _____

Nurse/Key Office Contact: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acromegaly | <input type="checkbox"/> Gynecomastia | <input type="checkbox"/> Pheochromocytoma |
| <input type="checkbox"/> Adrenal Incidentalomas | <input type="checkbox"/> Hirsutism | <input type="checkbox"/> Pituitary Adenomas |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Prolactinoma |
| <input type="checkbox"/> Cancer of Endocrine Glands | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Syndrome of Inappropriate Hormone Secretion |
| <input type="checkbox"/> Conn's Syndrome | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Thyroid Cancer |
| <input type="checkbox"/> Cushing's Syndrome | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Thyroid Nodule Biopsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Weight Loss/Nutrition Consult |
| <input type="checkbox"/> Diabetes Insipidus | <input type="checkbox"/> Parathyroid Gland Disorder | |
| <input type="checkbox"/> Other: _____ | | |

Please Attach a Copy of the Patient's Insurance Card, Pertinent/Last Visit Note, Labs and Imaging Studies.