UNITY HEALTH
TORONTO

Caring hearts. Leading minds.

St. Michael Hospital
Division of Endocrinology & Metabolism
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ENDOCRINOLOGY REFERRAL

Requesting Health Care Provider	Patient Information (as per OHIP card)
Name:	**Last Name:**
Address:	**First, Middle Name:**
	DOB:
Phone Number:	**Sex:** **M** ◯ **F** ◯ **Other** ◯
	Address:
Billing Number:	**Phone Number:**
	HCN: **Version:**
	Unity Health MRN (if applicable):

Specific Provider (if applicable): ____
(Note: referrals are triaged centrally: if the case is outside the area of focus of your preferred provider, the referral will be re-directed)
[ ] OR, tick box if you would like the patient booked with the first available provider

Reason for referral: (provide as much detail as possible)

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[ ] Urgent; please indicate reason for urgency: ____________________________________

Please attach all relevant laboratory results and imaging to the referral. (If not included, the referral may be declined)

Please note:
- We ask that patients come into our office for their appointments so we can thoroughly assess their needs.
- We recognize that patients may live out of the GTA. If they are unable to come into the office for their health care needs, we urge you to find a local care provider, where available.
    - o There are occasions where referrals for virtual care will be accepted (e.g. requirement for tertiary level care).
- Second opinions may be considered if unique circumstances (e.g. highly specialized care).
- Criteria may NOT apply to pregnant patients or perioperative patients delivering or undergoing surgery at St. Michael's Hospital.

June 2025

Endocrine Issue	Priority given to those with:
Weight loss	Identified endocrine abnormality: - TSH < 0.35 (or lower limit of laboratory reference range) - 8 am cortisol < 400 mmol/L - BG > 12 mmol/L **Refer to diabetes clinic*
Weight gain/obesity*	Endocrine causes of weight gain/obesity: - ↑ cortisol (urinary cortisol > upper limit of laboratory reference range, or 1 mg overnight dexamethasone test cortisol > 50 mmol/L) - Hypothyroidism (refractory to replacement therapy) - Concern for insulinoma Concurrent Diabetes**Refer to diabetes clinic* **Suggest referral to dedicated weight management program for muti-disciplinary approach and to explore treatment options such as a bariatric centre (https://www.ontariobariatricnetwork.ca/our-programs/medical-program) or e.g. the Wharton Clinic (https://whartonmedicalclinic.com/)*
Thyroid nodule*	Nodules meeting TIRADS criteria for biopsy: **Larger nodule(s) suspicious for thyroid cancer on US** **TR3** (Mildly Suspicious) ≥ **2.5cm, or** **TR4** (Moderately suspicious) ≥ **1.5cm, or** **TR5** (Highly Suspicious) ≥ **1cm** **Suggest ultrasound examination reported using the TIRADS classification system if not done* *- If only follow up ultrasound examinations are required, we recommend ultrasound follow-up as per report* *- [CCOThyroidDiagnosisPathway.pdf (cancercareontario.ca)]*
Hypothyroidism*	• Central hypothyroidism (low TSH, low fT4) • Overt hypothyroidism refractory to replacement therapy **For subclinical hypothyroidism (TSH greater than upper limit of normal, normal free T4) which indicate subclinical hypothyroidism.), indications for treatment include: 1) TSH > 10; 2) symptoms; 3) dyslipidemia, concurrent statin therapy; 4) pregnancy.* *For any of the above indications, a trial of levothyroxine 25 to 50 mcg po daily can be suggested, titrating to a TSH greater than lower limit of normal to 2.0.* **For Hashimoto's thyroiditis with normal TSH (TSH in normal reference range, + TPO or TG antibody), there are no indications for treatment, but TSH should be monitored every one to 2 years, or while contemplating pregnancy.*
Fatigue*	Identified endocrine abnormality: - TSH > upper limit of laboratory reference range - Low TSH and low T4 (central hypothyroidism) - Calcium > upper limit of laboratory reference range - Diabetes **Refer to diabetes clinic* - 8 am cortisol < 400 mmol/L **https://www.cmaj.ca/content/cmaj/174/6/765.full.pdf*
Female reproductive*	"PCOS" with diagnostic uncertainty: Recommend the following tests for diagnostic clarification and referral if abnormal: - day 3-5 8 am measurement of 17-OH-progesterone > 6.0 nmol/L (with concurrent low progesterone to confirm follicular phase) - 24 hour urine cortisol > upper limit of normal of lab - signs of virilization **Uncomplicated PCOS: Recommend metabolic screening for women with PCOS (Oral glucose tolerance test at diagnosis and every 1-3 years, Weight and waist measure yearly, fasting lipid profile and cardiovascular risk assessment)* **PCOS patients desiring fertility: Recommend referral to a fertility centre.*
Pregnancy	• Hypothyroidism (TSH>upper limit of trimester-specific laboratory reference range^) • Overt hyperthyroidism (TSH< lower limit of trimester-specific laboratory reference range^ AND high fT4) **"Suppressed" TSH and normal fT4: In the first trimester of pregnancy, a TSH level below the non-pregnant lower limit (0.4 mU/L) is observed in as many as 15% of healthy women most often due to the normal changes in pregnancy where the increased levels of human chorionic gonadotropin (hCG) during early pregnancy weakly stimulate the thyroid. Suppressed serum TSH levels during the first to early second trimester of pregnancy are not associated with altered maternal or neonatal outcomes.* *Retest TSH and fT4 in 4 weeks and after hCG peaks at 10 weeks gestation:* *- If persistent subclinical hyperthyroidism (low TSH and normal free T4), recheck again after 14 weeks.* *- If levels worsen with overt hyperthyroidism (low TSH and high Free T4), refer back for urgent assessment.* *^Suggested TSH reference range during pregnancy are 0.1–2.5 mIU/L (first trimester), 0.2–3.0 mIU/L (second trimester), and 0.3–3.5 mIU/L (third trimester).*
Male hypogonadism	• Unequivocally low morning, fasting total testosterone (repeated twice for confirmation) with symptoms of sexual dysfunction • If confirmed, order LH, FSH, prolactin to expedite work-up **Given the lack of specificity of symptoms, a consultation would be unlikely beneficial in a patient with symptoms and a normal total testosterone and alternative non-endocrine causes should be explored in these cases such as urologic, neuropathic, etc.*
Transgender care	* Due to a very large volume of referrals received, we are unable to accept new referrals. Please refer to the Rainbow Health Ontario website (service provider directory) to find providers who are accepting new patients.