

TESTOSTERONE CLINIC REFERRAL FORM

Dr. Jimmy Kwok
Please complete all sections below
and attach any pertinent information.



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DEMOGRAPHICS:

Patient Name _____ DOB (mm/dd/yyyy) _____

PHN _____ Tel _____ Sex: M F

Address _____

Primary Contact Name _____ Relationship _____

Tel or Email for all appointments _____

REASON FOR REFERRAL (check all that apply):

- Testosterone deficiency male ** must be over age 40
- Testosterone deficiency female (please note Dr. Kwok does not follow for concurrent progesterone and estrogen replacement but can provide guidance to primary care physician regarding this)

Past Medical History: Please list or attach to referral package

Medications: Please list or attach to referral package

Please attach relevant and recent laboratory or radiology reports and relevant consultant reports.

Referring Physician _____ MSP Number _____

Family Physician (if different than Referring) _____

Please note that patients are seen at the Pacific Internist Group which shares an office with the Pacific Geriatricians Group. For a PDF of this form please go to www.PacificGeriatricians.com