Children's Physician Group–Endocrinology

Guidelines for referrals

Below is a list of guidelines to follow when referring a patient for a consultation to Children's Physician Group–Endocrinology. These are meant to be general recommendations. If you have specific questions, call **404-785-DOCS (3627)** and ask to speak with the on-call endocrinologist.

Common conditions treated

- Adrenal disorders (e.g., adrenal insufficiency)
- Bone disorders
- Calcium disorders, including hypercalcemia and hypocalcemia
- Cholesterol disorders
- Congenital adrenal hyperplasia
- Cushing syndrome
- Delayed, absent or early puberty
- Diabetes insipidus
- Disorders of the anterior pituitary gland
- Disorders of sex development
- Gender dysphoria
- Growth disorders
- Gynecomastia in males
- Hirsutism in females
- Hypoglycemia
- Prader-Willi syndrome
- Prolactin disorders
- Rickets
- Short stature
- Syndrome of inappropriate antidiuretic hormone (SIADH)
- Thyroid nodules
- Thyroid disorders, including hyperthyroidism and hypothyroidism
- Turner syndrome
- Type 1 diabetes mellitus
- Type 2 diabetes mellitus

Urgent referrals

If you feel your patient needs to be seen as soon as possible, note "urgent" on your referral. All referrals marked "urgent" are triaged to help make sure patients are seen in a timely fashion. If you wish to speak to the on-call endocrinologist, call 404-785-DOCS (3627). Generally, conditions that may warrant an urgent initial outpatient visit include, but are not limited to:

- New Type 1 or 2 diabetes
- Hyperglycemia (if fasting BG over 126 mg/dl or a random BG 2 hour or OGTT over 200 mg/dl)
- Congenital hypothyroidism (neonate)
- Goiter or palpable nodule, if clinical findings include asymmetric gland, increasing size or discomfort, abnormal thyroid biopsy
- Abnormal height velocity or crossing percentiles **and** associated with severe headaches and/or blurry vision
- Hypoglycemia and failure to thrive

Routine referrals

There are several conditions we see that may not warrant an urgent evaluation given the available resources. These may include, but are not limited to, the following:

- Short stature (current height less than 3rd percentile for age or crossing percentiles on repeated growth measurements)
- Precocious puberty >7 years of age
- Delayed puberty
- Non-palpable nodule on thyroid (seen on ultrasound)
- Possible hypothyroidism with TSH <20 uIU/ml
- Congenital hypothyroidism (already on treatment)

Referral checklist and guidelines for common diagnoses

When referring a patient for any reason, except gender dysphoria, you must include office notes and growth curves. Otherwise, we will not be able to schedule your patient. In the table below, we have listed the labs and/or documents we require for the most common referrals. If the suspected diagnosis is not listed below, you only need to include office notes, labs that have already been ordered and visual growth curves with plotted points (multiple points are preferred, if applicable).

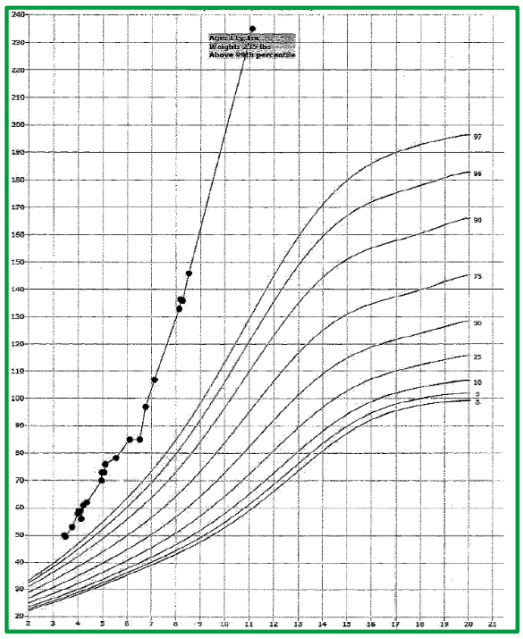
Suspected diagnosis	Labs/documents required before scheduling	Criteria for referral	Steps to take if criteria are not met, but concern for condition still exists
Abnormal thyroid function	□ Office notes □ Growth curves □ Free T_4 □ TSH	• Goiter present • TSH rises above 9 uIU/mL • Free T_4 below 0.8 ng/dL and/or total T_4 below 5 mcg/dL **and** • BMI <85%	If initial thyroid-stimulating hormone (TSH) is high, but <9 uIU/mL, repeat labs in one month with TSH, free T_4, thyroid peroxidase autoantibody (TPO) and antithyroglobulin autoantibodies (ATG). Document thyroid exam. If there is no goiter and BMI >85%, TSH remains minimally elevated and autoantibodies are both negative, TSH should return to normal after weight loss is achieved. Guidelines for repeated labs: • If both antibodies are negative, T_4 is normal and TSH remains < 8.9 mIU/L, no further testing is required. • Re-refer your patient if results demonstrate: – TSH between 4-8.9 mIU/L **and** – Free T_4 <0.8 ng/dL or total T4 <5 mcg/dL **or** – Positive thyroid antibodies **or** – Abnormal thyroid exam
Hyperlipidemia	□ Office notes □ Growth curves □ Fasting lipid panel	*Coming soon*	See guidelines for LDL and triglycerides identified below.
Hypoglycemia	□ Office notes □ Growth curves □ Glucose	*Coming soon*	*Coming soon*
Diabetes, obesity, metabolic syndrome	□ Office notes □ Growth curves □ A1c *If a patient has an established diabetes diagnosis, send all available records with focus on initial lab eval.*	Due to the large volume of referrals of this nature, we redirect patients with an A1c <6.5% to Strong4Life, regardless of acanthosis or hyperinsulinemia	For possible Type 2 Diabetes, two abnormal values are required to diagnose diabetes in the absence of symptoms. Values include: □ Fasting glucose >126 mg/dl **or** □ 2-hr post-prandial glucose >200 mg/dl **or** □ A1c >6.5%
Short stature and poor weight gain	□ Office notes □ Growth curves	• Poor weight gain **and** • Abnormal growth velocity	If growth velocity is well maintained but weight gain appears to be lacking, growth hormone or thyroid hormone deficiency is an unlikely cause for poor growth. In this case, we recommend a referral to gastroenterology.

Suspected diagnosis	Labs/documents required before scheduling	Criteria for referral	Steps to take if criteria are not met, but concern for condition still exists
Cushing syndrome	□ Office notes □ Growth curves	• Signs of short stature • Hypertension • Proximal limb muscle wasting or weakness **or** • Diabetes	Continue to monitor for abnormal test results and/or symptoms.
High LDL cholesterol	□ Office notes □ Growth curves □ Fasting lipid panel	• LDL ≥190 mg/dL • Moderate elevation (130-189 mg/dL), no response to lifestyle management after 6 months **and** any of the following risk factors: – Smoking – Diabetes – Nephrotic syndrome – Renal failure – Renal transplant – History of Kawasaki disease – HIV – Chronic inflammation – Cancer survivor – Family history of premature cardiovascular disease	For moderate elevation (130-189 mg/dL), lifestyle management is recommended for all patients for at least 6 months before referring to endocrinology.
High fasting triglycerides	□ Office notes □ Growth curves	• High fasting triglycerides and low HDL (<20mg/dL) • Levels >300 mg/dL	Abnormal levels that are <300 mg/dL may respond to lifestyle management plus-or-minus fish oil.
Polycystic ovarian syndrome (PCOS)	□ Office notes □ Growth curves	• Irregular or absent ovulation • Clinical signs of high androgens (e.g., hirsute and severe acne)	A combined oral contraceptive pill (OCP) is the first line of therapy. Use OCP with low androgen activity. Consider the risk for thrombosis before starting OCP. Metformin is used by some, but it is not an FDA-approved indication. Differential diagnosis of adrenal disease or an ovarian tumor can be evaluated with minimal investigation. • 17-hydroxyprogesterone • Free testosterone • DHEA-S • TSH • Fasting complete metabolic profile • Fasting lipid profile • hCG (urine or serum) • ± 25 (OH) vitamin D

Growth curves

We require growth curves for all referred patients prior to scheduling. Note, it is very important to provide a **visual line graph**, ideally for both height and weight, although both are not required. Multiple points are preferred, *if available*. If you have only seen the patient once, we will accept graphs with single points.

Sufficient



Insufficient

Vitals with Age Percentiles	8/11/2016	12/15/2016	7/20/2017	4/20/2018	4/20/2018	6/20/2019	6/20/2019
Height percentile		64.1 %	79.1 %		60.5 %		66.9 %
Systolic percentile							
Diastolic percentile							
Weight percentile	38.2 %	39.4 %	32.7 %		61.3 %		42.6 %
Head Circumference percentile		98.4 %					
Length		95.3 cm	99.1 cm		102 cm		114.5 cm
Systolic			90		94		90
Diastolic			58		50		62
Head Circumference		20.250					
Pulse							
Weight	27 lb	28 lb 6.1 oz	30 lb		36 lb 4 oz		39 lb 6.1 oz
Body Mass Index				15.8 kg/m2		13.63 kg/m2	
Body Mass Index percentile		5.7 %	4.3 %		65.0 %		6.8 %
BODY SURFACE AREA				0.68		0.75	

Office notes

Office notes are crucial in helping us determine the intricacies of your patient's case. Note, we require office notes *beyond* just the reason for referral. Whether you refer to them as Clinical Notes, History of Present Illness (HPI), Interval History or Notes, what we need are notes that the provider took during the last visit that explain the child's case and chief concern. A short "reason for referral" is **not** sufficient. See examples below.

Insufficient

Referral
Date requested: 08/16/2021
Requested by: FirstName LastName, NP
Referral to: pediatric endocrinology
Summary of care provided:
Reason for referral/notes: breast buds and pubic hair
ICD code: Precocious puberty (ICD-10: E30.1)

Sufficient

PatientName is a XX-year-old female seen for follow-up visit via telemedicine for anxiety, depression and gender identity issues. Guardian called for crisis appointment as PatientName was distressed about breast development. Reports that she has never liked her body since age XX and identifies as a boy (symptoms worsened when she hit puberty). Patient would like to transition and talk about the process. Family is supportive.

Anxiety and depression: Overall mood has been stable. Not sleeping well, but can focus on schoolwork. Denies self-harm or suicidal thoughts.

Insomnia: Reports improved sleep with clonidine 0.1 mg at night.

Diagnosis	• Congenital hypothyroidism ICD-10: E03.1: Congenital hypothyroidism without goiter
Order Name	Orders included: 1 Congenital hypothyroidism ICD-10: E03.1: Congenital hypothyroidism without goiter • PEDIATRIC ENDOCRINOLOGIST REFERRAL **Schedule within**: provider's discretion
Notes	6 mo. male, former 30-week premature delivery – with congenital hypothyroidism, h/o elevated TSH x3 on newborn screenings. Presented for primary visit on [date], repeat TSH elevated to 5.4, normal free T4. Telephone consult with Dr. LastName. Advised to refer to pediatric endo at 6 mo. of age. Please evaluate and assist.