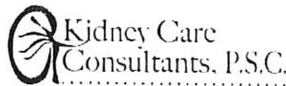

Board Certified • Internal Medicine • Nephrology

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Phone: (502) 595-7744 or (502) 425-9121 Fax: (502) 595-7007 or (502) 425-9161

Referral Request Form

Thank you for choosing to refer your patient to us. To start the referral process, please fax this form with supporting documentation to our office. If you have any questions, please call our office and we will be happy to assist you.

Referring Provider Information

Referred by (DR):______________________________Medical Group:___________________________________

Phone: (____)_____-________Fax: (____)_____-________PCP(if other than referring):______________________

Address:________________________________City:__________________State:____Zip:_______

This form completed by:________________________________Date:_____________________

Patient Information (please attach patient demographics)

Last Name:_________________________________First Name:__________________________MI:____

DOB:__________________ Gender: M / F SSN:_____________________

Phone: (____)________-__________ Needs Interpreter? Y / N Language:___________________

Reason for Referral

eGFR
Resistant or suspected secondary hypertension
Diabetic Nephropathy
Acid/Base Disorders
Electrolyte Disorders
Chronic Kidney Disease
Proteinuria
Edema
Anemia (related to kidney)
Acute Kidney Injury/Failure
Elevated Serum Creatinine
Kidney Stone/Cysts/Masses

Other:____

Documentation Required (please fax with this form):

- ☐ Two (2) recent/relevant clinical notes and/or test results, i.e. history and physical, CT/X-ray results, Renal Ultrasound results
- ☐ At least 2 recent/ relevant lab results
- ☐ Medication List
- ☐ Proof of Insurance
- ☐ Authorization information (if required)
- ☐ Patient Demographics

Does this patient need a referral from their insurance company?

YES ☐ **NO** ☐

REFERRAL NUMBER______________