Kidney Care Consultants, P.S.C.
Board Certified * Internal Medicine * Nephrology
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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	Proteinuria
Resistant or suspected secondary hypertension	Edema
Diabetic Nephropathy	Anemia (related to kidney)
Acid/Base Disorders	Acute Kidney Injury/Failure
Electrolyte Disorders	Elevated Serum Creatinine
Chronic Kidney Disease	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_____