Nephrology Associates, PC

Referral Request

Patient Name: _____

DOB: _____

Reason for Consultation (circle all that apply)

Renal Insufficiency	Hematuria	Hyponatremia
CKD	Hypernatremia	Other: _____
Hyperkalemia	Proteinuria	
Hypokalemia	Hypertension	

Fax All Information Listed Below

APPOINTMENT WILL NOT BE MADE UNTIL REQUESTED RECORDS ARE RECEIVED

Demographics with full Social Security Number, Copy of Insurance Card (s) (Front and Back), Recent Office Notes, Med List, 12 months of labs (including most recent labs (CMP and BMP) , Abdominal Imaging Reports (if on file; US,CT, MRI).

Please FAX to: 615-221-9596

Referring Physician: _____ Contact Person: _____

Phone Number: _____ Fax number: _____

We will fax this request back to the referring Physician's office within 2 business days after receiving the request with appointment date and time.

Thank you,

Anne Turnage

Referral Coordinator

This Box is for Nephrology Associates Office Use Only

Appointment Date: _____

Appointment Time: _____

Provider patient is scheduled with _____

Initial & Date _____