Referral Request Form

PatientName: ________________________________ **Date of Birth:** ___________________

Diagnosis/ Reason for Consult: Elevation of Creatinine Proteinuria

Circle all that apply Hypertension Hematuria

Abnormal Imaging Study Family History of Renal Disease

Abnormal Laboratory Studies History of Renal History

Other:____________________________________

Urgency: Routine ASAP STAT (Physician to Physician Only)

Consulting Physician Request: First Available Physician / Appointment

Circle your request Specific Consultant Requested: Dry:_________________

Offices: Reno Carson City Fallon

Circle your request Winnemucca Elko Ely

Please Include the following documents with all new patient referral requests:

1. Most recent physician evaluation (Office Notes, Hospital H & P, etc.)
2. Last 6 months of laboratory evaluations.
3. Any Pertinent imaging reports
4. Patient Demographics / Insurance information

Contact Us: (775)322-4550FAX: (775) 322-4775 or (775) 322-4776

All new patient forms can be found on our website: www.nevadakidney.com