



Patient Referral Request Form

Patient Name: _____ **D.O.B.:** _____

Specialty Request: (check all that apply)

- Sierra Nevada Nephrology Consultants
- Sierra Nevada Pulmonary & Sleep
- Sierra Nevada Endocrinology

Referring Provider: _____ **Phone #:** _____

Urgency:

- Routine
- STAT

Diagnoses/ Reason for Consult:

Please include the following documentation with all new patient referral requests:

- Most recent provider evaluation (Office notes, H&P, etc)
- Last 6 months of laboratory results (if applicable)
- Any pertinent imaging/pathology reports (if applicable)
- Patient demographic information
- Copy of the patient's ID and insurance card

Contact us:

Main line: 775-322-4550

New Patient Referral Team: 775-242-3025

Fax: 775-322-4775

nvspecialtycare.com