COLUMBIA NEPHROLOGY

NEW PATIENT REFERRAL FORM

CHECK ONE ☐ **COLUMBIA OFFICE** ☐ **NEWBERRY OFFICE** ☐ **LUGOFF ELGIN/CAMDEN OFFICE**

DATE: _____

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE:** _____

DOB: _____ **SS #:** _____

PHONE #: HOME: _____ **WORK:** _____ **CELL:** _____

PRIMARY INSURANCE: _____ **POLICY #:** _____

SECONDARY INSURANCE: _____ **POLICY #:** _____

WE CANNOT SCHEDULE YOUR PATIENT'S APPOINTMENT WITHOUT THIS COMPLETED FORM AND THE BELOW LISTED INFORMATION:

1. **Patient's information sheet, copy of patient's insurance card (front and back).**
2. **Copy of patient's medication list.**
3. **Any office notes, labs (BMP & CMP within the last year) or test results that pertain to the referral to our office.**

REASON FOR REFERRAL:

Chronic Kidney Disease
Hypertension
Acute Renal Failure
Renal Artery Stenosis
Proteinuria
Electrolyte Disorder
Other: _____

REFERRING MD: _____

NPI #: _____

UPIN #: _____ **Tax ID #:** _____

OFFICE CONTACT PERSON: _____

OFFICE PHONE #: _____ **FAX #:** _____

Please use this for your fax cover sheet and fax back to 252-9906. Thank you.