



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
Other: _____

Renal Artery Stenosis
Proteinuria
Electrolyte Disorder

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.

The information contained in this facsimile transmission is intended for the use of the individual to whom it is addressed and may contain information which is privilege, confidential and exempt from disclosure under applicable law. If you are not the intended recipient or the employee or agent responsible for delivering information to the intended recipient, you are hereby notified that any dissemination, distribution or copying for this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original facsimile, without retaining any copies to us at the address above via the US Postal Service.