COLUMBIA NEPHROLOGY

www.columbianephrology.com

NEW PATIENT REFERRAL FORM

Please Circle Location:

Columbia Office	Newberry Office	Lugoff/Elgin Office	Sumter Office	Lexington Office
121 Park Central Dr.	2850 Kinard St.	909 Carolina Dr.	115 North Sumter St.	3630 Sunset Blvd.
Columbia, SC 29203	Newberry, SC 29108	Lugoff, SC 29078	Sumter, SC 29150	West Columbia, SC 29169
P: 803-252-9907	P: 803-252-9907	P: 803-252-9907	P: 803-938-5421	P: 803-999-1448
F: 803-252-9906	F: 803-252-9906	F: 803-252-9906	F: 803-938-5411	F: 803-849-8347

PATIENT NAME: _____ **DATE:** _____

ADDRESS: _____

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

DOB: _____ **SS #:** _____

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

PATIENT'S E-MAIL ADDRESS: _____

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

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

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

- ☐ **Copy of patient's insurance card (front and back).**
- ☐ **Patient's medication list.**
- ☐ **Last Office Visit Note (please only send one)**
- ☐ **Last 2 sets of labs or trending labs (BMP & CMP within the last year).**
- ☐ **Test results that pertain to the referral to our office. Renal Ultrasound report if available.**

REASON FOR REFERRAL:

Chronic Kidney Disease	**Renal Artery Stenosis**
Hypertension	**Proteinuria**
Acute Renal Failure	**Electrolyte Disorder**

Other _____

REFERRING PROVIDER: _____

IF NP/PA is referring provider, (MUST INCLUDE SUPERVISING MD) _____

OFFICE CONTACT PERSON: _____

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

Please use this for your fax cover sheet and fax back to selected office. Thank you.