



C O L U M B I A N E P H R O L O G Y

www.columbianephrology.com

NEW PATIENT REFERRAL FORM

Please Circle Location:

Columbia Office
121 Park Central Dr.
Columbia, SC 29203
P: 803-252-9907
F: 803-252-9906

Newberry Office
2850 Kinard St.
Newberry, SC 29108
P: 803-252-9907
F: 803-252-9906

Lugoff/Elgin Office
909 Carolina Dr.
Lugoff, SC 29078
P: 803-252-9907
F: 803-252-9906

Sumter Office
115 North Sumter St.
Sumter, SC 29150
P: 803-938-5421
F: 803-938-5411

Lexington Office
3630 Sunset Blvd.
West Columbia, SC 29169
P: 803-999-1448
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
Hypertension
Acute Renal Failure
Other _____

Renal Artery Stenosis
Proteinuria
Electrolyte Disorder

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.

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