TENNESSEE
KIDNEY CARE


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## NEW PATIENT REFERRAL FORM

Patient's name: _____ DOB: _____ SEX: ☐M ☐F

Patient's phone: _____ Alt phone: _____

Referring physician: _____ PCP (if different): _____

Reason for referral:

- ☐ Chronic Kidney Disease(CKD)
- ☐ Hypertension & Edema
- ☐ Electrolyte Abnormalities
- ☐ Kidney Stones (Nephrolithiasis)
- ☐ Proteinuria
- ☐ Hematuria
- ☐ Cystic Kidney Disease
- ☐ Acute Kidney Injury (AKI)
- ☐ Other: _____

### IF URGENT, PLEASE CALL AND FAX THIS FORM

### Please include the following documentation with your referral:

- ☐ Demographics/insurance info
- ☐ Physician's visit notes
- ☐ Recent lab reports for the last 3–6 months
- ☐ Active medication list
- ☐ Ultrasound or CT scan of abdomen (if available)

Staff contact name: _____ Date: _____

Phone: _____ Fax: _____

**THIS BOX IS FOR TENNESSEE KIDNEY CARE OFFICE USE ONLY**

Date _____ Time _____

Location: ☐ Athens ☐ Chattanooga ☐ Cleveland

Provider patient is scheduled with: _____

Initial & Date: _____

Unable to schedule patient due to: _____