

# **Nephrology Consultation Referral**

## **Patient Information**

Name:

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DOB:

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MRN:

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Phone:

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Address:

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## **Referring Provider**

Name:

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Phone:

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Fax:

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Practice/Facility:

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## **Reason for Referral**

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## **Relevant Medical History**

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## **Current Medications**

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## **Recent Labs / Imaging / Notes**

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## **Additional Notes**

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Referring Provider Signature:

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Date:

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