INDIANA KIDNEY SPECIALISTS

New Patient Referral Form

Please fax completed form and all information to 317-924-8424 (all locations)

Attn: New Patient Coordinator We will schedule and notify patient of all appointment information.

Date:		Time:	

Referring Physician Information

Referring MD:		Contact Person:	
Address:			
Phone:		Fax:	Pager:

Patient Information

Patient Name:			
SSN:		DOB:	
Address:			
City:		Zip:	
Home:	Cell:		Work:
Primary Insurance:		Policy #:	
Secondary Insurance:		Policy #:	
Contact person/number if other than patient:			

Diagnosis:									
Symptoms:	Date of on set:								
BUN:		Creatinine:		Potassium:		GFR:		CrCl:	
Total Protein:		Pro/Creatinine Ratio:		Urine Micro albumin:		Micro/Creatinine Ratio:		Total Volume:	

Office Location Preference

Methodist		South		Franklin		Carmel		Fishers	
West		Mooresville		Martinsville		Greencastle		East	

CERNER MRN		St Francis MRN		Community MRN		Other	
Demographics:		Ins Cards Front & Back		Medication List:			
Last 2 progress notes:		Labs – 1 years' worth if available					
Renal Ultrasound:		Abdominal CT Scan:					
Would you like to be notified of scheduled appointment:							

NIM STAFF NOTES: _____

_____