

Kidney and Pancreas Division Referral Form

Patient Name: <i>(please print clearly)</i>	Date of Referral:	SSN:
Address:	Date of Birth:	Single Divorced Married Widowed
City, State, Zip:	Sex:	Race:
Have there been any non-compliance concerns in the last 3 months? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide supportive documentation.	Home Phone:	Cell Phone:
		Work Phone:

Is this referral for: (circle one) Kidney Only Pancreas Only or Kidney & Pancreas

<p style="text-align: center;">Nephrologist Information</p> <p>Referring Nephrologist: _____</p> <hr/> <p>Address City, State ZIP</p> <hr/> <p>Phone #: _____ Fax #: _____</p> <p>Cause of ESRD: _____</p> <p style="text-align: center;"><small>Mandatory field</small></p> <p style="text-align: center;">On <u>ALL</u> Patients:</p> <p style="text-align: center;">Please forward the following information to fax #: (405)713-7465</p> <table style="width: 100%;"> <tr> <td style="width: 50%;">Current Lab</td> <td style="width: 50%;">Cardiac Stress Tests</td> </tr> <tr> <td>H&P</td> <td>ECHO</td> </tr> <tr> <td>D/C Summary</td> <td>Colonoscopy</td> </tr> <tr> <td>EKG</td> <td>Ultrasounds</td> </tr> <tr> <td>Chest X-Ray</td> <td>CAT scans</td> </tr> </table>	Current Lab	Cardiac Stress Tests	H&P	ECHO	D/C Summary	Colonoscopy	EKG	Ultrasounds	Chest X-Ray	CAT scans	<p>Does Patient have Indian Health Services? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p style="text-align: center;">Is Patient on Dialysis? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, list Date Started: _____</p> <p style="text-align: center;">Then provide the following information:</p> <p>Dialysis Center: _____</p> <hr/> <p>Address City, State ZIP</p> <hr/> <p>Phone #: _____ Fax #: _____</p> <p>Type: Hemodialysis <input type="checkbox"/> PD <input type="checkbox"/> Schedule: _____</p> <p>If patient is on Dialysis, please provide:</p> <p style="text-align: center;">Psychosocial History, Documentation of Hep B immunization, Last Flu Shot and Last Pneumo Vax Shot</p> <p>Check patient's special needs:</p> <p><input type="checkbox"/> Blindness <input type="checkbox"/> Illiterate</p> <p><input type="checkbox"/> Deaf <input type="checkbox"/> Does not speak English</p> <p><input type="checkbox"/> Other: _____</p>
Current Lab	Cardiac Stress Tests										
H&P	ECHO										
D/C Summary	Colonoscopy										
EKG	Ultrasounds										
Chest X-Ray	CAT scans										

Insurance Information

Primary: _____ Phone #: _____

Primary Policy #: _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ ID#: _____

Secondary: _____ Phone#: _____

Secondary Policy #: _____ Group #: _____

Policy Holder's Name: _____

Policy Holder's SSN: _____ ID#: _____