Nephrology Consult Referral Form

Date of Referral: ___________ Referring MD/NP/PA: ______________________

Patient Name: _____________________________ DOB: ____________________

Patient Phone Numbers: ____

Referral Source:

- ❑ Internal/Family Medicine
- ❑ Rheumatology
- ❑ Oncology
- ❑ Other: ________________________________
- ❑ Endocrinology
- ❑ Cardiology
- ❑ General Surgery

Dialysis required: ❑ Yes ❑ No

Baseline creatinine and Date: ____________________ or ❑ unknown

Baseline Microalbumin/Creatinine Ratio __________________ or ❑ unknown

If Diabetic Baseline A1C and Date ________________________

If Hypertensive last BP and Date _________________________

If had Renal Ultrasound, date of study ____________________

Additional details (Attach relevant labs and documents):

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Fax Consultation Requests to—510-848-9970

Clinic Assistant—510-841-4525

All CKD clinics are held at East Bay Nephrology Offices.

The target appointment date is within 60 days, unless otherwise requested