Athens Kidney Center

Patient Referral & Information Form

Date: _____ **Referring Physician:** _____

Please indicate urgency of referral: Routine ☐ Urgent ☐ Expedite ☐

Patient Name: _____

Address: _____ City/State/Zip: _____

Home phone: (____)_____ Work phone: (____)_____

Date of Birth: ____/____/____ Last 4 digits SS#: _____ Sex: ____ Race: _____

Reason for referral: _____

Has patient already been referred to a specialist? Yes No

If yes, to whom: _____ ☐ ☐

_____

Please attach all relevant medical records (labs, diagnostic study reports, patient notes, etc.) if referral is for specialty care outside of referring physician office

Person completing form: _____

_____

Phone: (_____)_____ Fax: (_____)_____

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Referral Status: Approved ☐ **Appointment:** _____

Denied ☐

Notes:

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