NHC

NEPHROLOGY AND HYPERTENSION CONSULTANTS, P.A.

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New Patient Referral Form

Referring Physician Contact Information

Contact Person: _____ **Today's Date** _____

Practice Name: _____ Phone #: _____

Referring Physician: _____ Fax #: _____

Address: _____ NPI #: _____

Patient Information

Name: _____ DOB: _____ SSN: _____

Gender: _____ Race: _____ Marital Status: _____ Language Spoken by Patient: _____

Address: _____ Phone #: _____
City/Zip

Primary Insurance: _____ Policy Holder: _____ DOB: _____

Policy/ID#: _____ Group #: _____ Employer: _____

Secondary Insurance: _____ Policy Holder: _____ DOB: _____

Policy/ID#: _____ Group #: _____ Employer: _____

Appointment Information

Diagnosis: (required) _____ Preferred NHC Physician: _____

Urgency of appointment: [provide documentation] _____

Serum BUN _____ Creatinine _____ Albumin _____ Potassium _____ Other _____

FAX: Insurance Cards, Progress Notes, Labs, Radiology, etc. to 704-503-4030 prior to appointment. Notify your patient of the date and time of his/her appointment and reason you are referring him/her to us. (If no physician preference is made on the referral form, the patient will be scheduled with first available.

OFFICE USE ONLY: Appt Date: _____ Time: _____ Physician: _____

Date information packet mailed to patient: _____ Initials: _____