KIDNEY SPECIALIST, INC.

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Phone: 559-661-1965 | Fax: 559-661-1952

NEW PATIENT REFERRAL FORM

Date: _____

Referring Provider Details

Referring Physician: _____ Specialty: _____

Lic#: _____ NPI: _____ Contact Person: _____

Phone: _____ Fax: _____

Patient Details

Patient's Name: _____ D.O.B.: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ SS#: _____

Primary Language: _____ efer AM/PM: ☐ AM ☐ PM

Day Preference: ☐ Tues ☐ Wed ☐ Thurs

Insurance Information

Primary Insurance: _____ Phone: _____

Secondary Insurance: _____

Was Authorization Obtained? ☐ Yes ☐ No Name of person you spoke with: _____

Authorization good through dates: _____ to: _____

Consultation Request

Consultation Date: _____ Appt. Time: _____

You may fax this request to (559) 661-1952 along with a copy of the patient's insurance cards front and back along with all pertinent records, including all doctors' notes, pathology reports, labs, x-ray reports, or hospital records.