# New Patient Referral Form

| Date: | | Time: | |
|---|---|---|---|

Referring Physician Information

| Referring MD | | Person Calling | | | |
|---|---|---|---|---|---|
| Physician Address | | | | | |
| Phone | | Fax | | Pager | |

Patient Information

| Patient Name | | | | | |
|---|---|---|---|---|---|
| SSN | | DOB | | | |
| Address | | | | | |
| City | | Zip | | | |
| Home | | Cell | | Work | |
| Primary Insurance | | Policy # | | | |
| Secondary Insurance | | Policy # | | | |

| Diagnosis | | | | | |
|---|---|---|---|---|---|
| Symptoms | | | | | |
| BUN | | Creatinine | | Potassium | |
| CrCl | | Total Protein | | GFR | |

Office Location Preference

| Methodist | | St. Francis | | Clarian West | | Clarian North | |
|---|---|---|---|---|---|---|---|

Appointment Information – (to be completed by NIM staff)

| Account # | | Appt Date | | Appt Time | |
|---|---|---|---|---|---|
| Doctor | | Office | | Dialysis Ctr | |

| Requested Records | | Packet Sent | |
|---|---|---|---|
| Patient Notified | | Ref Doc Notified | |

| Cancelled Appointment | | No Showed Appointment | |
|---|---|---|---|
| Reschedule Date | | Reschedule Time | |
| Patient Notified | | Ref Doc Notified | |