

The Kidney and Hypertension Center

NEPHROLOGY CONSULTATION REQUEST

In an effort to satisfy the current federal compliance requirements related to consultations, we ask you to complete this nephrology consultation request form.

Please complete this form including the reason for the consult and the signature of the referring physician.

Patient Name: _____ Phone #: _____ Date: _____

DOB: _____ SS #: _____

The following records are necessary for our physicians to review prior to the patient's appointment:

- 1) Completion of this request form for nephrology consultation
- 2) Copies of:
 - a. six (6) months of office notes, including vitals such as blood pressure
 - b. six (6) months of diagnostic testing results, including radiology reports and laboratory studies (blood and urine)
 - c. diagnosis list
 - d. medication list
- 3) Insurance referral when applicable

Insurance: _____ Referral Required: Y** N

**An appointment will be scheduled after insurance confirmation is received, i.e. authorization number, form(s), etc.

To provide your patient with the best care and to help us to schedule him/her in a timely fashion, please send all of the above information.

Referring Physician: _____

Phone #: _____ Fax #: _____

Consultation Request for KHC Physician: _____

Office Location: _____

Reason for Consultation: _____

Referring Physician's Signature: _____ MD/DO

Please e-mail this consultation request to referrals@khc.cc. The patient's records can be mailed or faxed to:

3219 Clifton Avenue, Suite #325, Cincinnati, Ohio 45220 -- fax: (513) 861-5111

830 Thomas Moore Parkway, Suite #202, Edgewood, Kentucky 41017 -- fax: (859) 341-4661