Apt date:	Apt Time:
Dr:	Loc:
New Patient Referral Form	CHART #

Thank you for your referral to Indiana Kidney Specialists

Please complete this form and send to the attention of: Sue

And fax to 317-924-8424

We will schedule and notify patient of all appointment information.

Date:		Time:	

Patient Information

Patient Name:					
SSN:		DOB:			
Address					
City:		Zip:			
Home:		CELL		Work:	
Primary Insurance:		Policy #:			
Secondary Insurance:		Policy #:			
Contact person/number if other than patient:					

Referring Physician Information

Referring MD:		Contact Person:	
Address:			
Phone:		Fax:	

Diagnosis:									
Sodium									
BUN:		Creatinine:		Potassium:		GFR:	/	CrCl:	
Total Protein:		Pro/Creatinine Ratio:		Urine Micro albumin:		Micro/Creatinine Ratio:		Total Volume:	

Office Location Preference

West/Parkdale		South 131		Fishers		Kokomo	
Terre Haute		Martinsville		Greencastle		East	

PLEASE FORWARD THE FOLLOWING INFORMATION W/ ALL REFERRALS

CERNER MRN		St Francis MRN		Community MRN		Other	
Demographics:		Ins Cards Front & Back		Medication List:			
Last 2 progress notes:		Labs – 1 years' worth if available					
Renal Ultrasound:		Abdominal CT Scan:					
Would you like to be notified of scheduled appointment:							

IKS STAFF NOTES: _____

_____

_____

Call 1:	Call 3:	Packet Sent:
Call 2:	Letter Sent:	