Kidney Care & Transplant Services of New England

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NEW PATIENT REFERRAL FORM **TODAY'S DATE: _____**

PATIENT INFORMATION:			
PATIENTS NAME:	**DATE OF BIRTH:**	**HOME PHONE:**	**CELL PHONE:**

PARENT/GUARDIAN INFORMATION (If applicable)		
NAME:	**HOME PHONE:**	**WORK PHONE/ CELL PHONE:**
RELATIONSHIP TO PATIENT:		

PRIMARY CARE/REFERRING PHYSICIAN:	
REFERRING PHYSICIAN:	**OFFICE PHONE:**
ADDRESS/CITY/STATE/ZIP:	**OFFICE FAX:**
OFFICE CONTACT:	**PHONE:** **EXTENSION:**
PRIMARY CARE PHYSICIAN (If different):	**OFFICE PHONE:**
ADDRESS/CITY/STATE/ZIP:	**OFFICE FAX:**

REFERRAL INFORMATION:	
REASON FOR REFERRAL (clinical question):	**TYPE OF SERVICE DESIRED:**
IMPORTANCE: ROUTINE [ ] (approx. 3-4 wks) URGENT [ ] (24-72hrs)	**[ ] CONSULT ONLY (EVALUATE & ADVISE)**
PRECAUTIONS/SPECIAL INSTRUCTIONS FOR OFFICE:	**[ ] COMPLETE TRANSFER OF CARE**
	[ ] CO-MANAGEMENT WITH SHARED CARE
	[ ] CO-MANAGEMENT WITH PRINCIPAL CARE

***** PLEASE FAX THE FOLLOWING INFORMATION ALONG WITH THIS REFERRAL FORM TO 413-507-0342 *****
**** ANY MISSING INFORMATION WILL CAUSE A DELAY IN SCHEDULING ****

[ ] DEMOGRAPHICS & INSURANCE [ ] RECENT OFFICE NOTE(S)

[ ] MEDICATION LIST [ ] RECENT LAB RESULTS

[ ] ANY RELEVANT DIAGNOSTIC TEST RESULTS – CT SCANS, MRI, ULTRASTOUNDS

Provider Referral Confirmation:

FOR KIDNEY CARE & TRANSPLANT OFFICE USE ONLY: APPOINTMENT INFORMATION / TRACKING		
DATE REFERRAL FORM RECEIVED:	**DATE APPOINTMENT SCHEDULED:**	**SCHEDULED BY:**
PROVIDER:	**LOCATION:**	
APPOINTMENT DATE & TIME:		**RECORDS SCANNED: Y [ ] N [ ]**
REQUEST FOR ADDITIONAL INFORMATION (please detail):		