INDIANA NEPHROLOGY
&
INTERNAL MEDICINE, P.C.

NEW PATIENT REFERRAL FORM

Date_____

Referring Physician_____

Office Phone: _____ Office Fax: _____

To make a referral, please complete the following form and fax to the appropriate INIM office. We will contact your patient to schedule an appointment, and we will notify you of the date and time. Please fax demographic information, insurance referral authorization (if required), medication list, problem list, last 2-3 office notes, last 2 years of lab work, and any radiology reports pertaining to the kidney.

Preferred Office Location:

□ East (Fishers, Shelbyville, Greenfield, South Indianapolis)
Office Fax: 317-353-2389
□ North (Carmel, West Indianapolis)
Office Fax: 317-876-5580
□ Richmond (Connersville)
Office Fax: 765-962-4735
□ Noblesville (Elwood, Westfield)
Office Fax: 317-770-8910
□ Kokomo
Office Fax: 765-453-6889

Patient Information:

Name_____ DOB_____

Address: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Reason for referral:

□ Acute Renal Failure
□ Chronic Kidney Disease
□ Hyponatremia
□ Hematuria / Proteinuria
□ Kidney Stones
□ Hypertension
□ Nephrotic Syndrome / Proteinuria
□ Polycystic Kidney Disease
□ Renal Artery Stenosis
□ Other_____

If your patient has a more urgent problem and needs to be seen sooner, or if the patient is pregnant, please explain:
_____
_____
_____
_____