

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, Fishers, West Indianapolis)

Office Fax: 317-876-5580

Richmond (Connersville)

Office Fax: 765-939-0035

Noblesville (Elwood, New Castle, 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

Hypertension

Chronic Kidney Disease

Nephrotic Syndrome / Proteinuria

Hyponatremia

Polycystic Kidney Disease

Hematuria / Proteinuria

Renal Artery Stenosis

Kidney Stones

Other _____

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