

Progressive Renal Insufficiency, Hypertension, End Stage Renal Disease

Referring Site to Complete and Fax to our Team FAX: 905-641-5218

- Dr. A. P. Broski
- Dr. M. Khandelwal
- Dr. D. Lagrotteria
- Dr. Eli Rabin
- Next Available Appointment (Any Nephrologist)

Patient Name: _____ **Health Card:** _____

Address: _____

Postal Code: _____ **Phone:** _____

Reason for Nephrology Referral _____

Referring Practitioner: _____ **Billing #:** _____

Fax: _____ **Phone:** _____

Thank you for referring this patient to the Renal Clinic. Upon receipt of this referral, our office will schedule the appointment and return the referral to you with any instructions. Your office is responsible to **CONTACT THE PATIENT AND ADVISE THEM OF THEIR APPOINTMENT DATE AND TIME.**

Referral Site to Complete:

Patient is scheduled to see: Dr. _____

Comments: _____

Instructions/ Additional Information Required – please provide via fax or electronically:

- Most recent Serum creatinine (required for all referrals for triage purposes)**
- Random urine for microalbumin/ creatinine ratio
- 24 hour urine collection for protein, creatinine clearance and creatinine
- Urinalysis R&M
- Serum creatinine, urea, electrolytes and total CO2
- FBS & Hgb A1C
- Calcium, phosphate, albumin
- CBC
- Serum protein electrophoresis
- Fasting cholesterol, triglycerides, LDL, HDL completed in the last 6 months
- Previous Serum Creatinine results
- Ultrasound of abdomen/renal current within the last year
- Echocardiogram (if available)
- _____
- _____

Please note – these results are needed as soon as possible in order to expedite the referral for your patient. We appreciate your support in sharing all relevant information related to this referral PRIOR TO THE APPOINTMENT DATE.