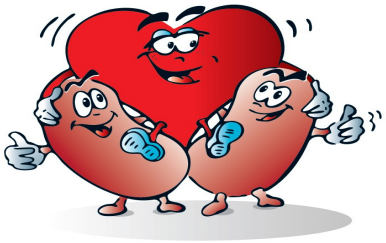

NEW PATIENT REFERRAL INFORMATION

NORTH GEORGIA NEPHROLOGY CONSULTANTS

Name: _____ SS#_____

Address:_____

City:_____ State:_____Zip:_____

Phone:_____Alternate #_____

Date Of Birth_____

Primary Ins:_____ Secondary Ins:_____

Completed by _____ Date _____

Dr Abid Bashir ☐ Dr Jolina Santos ☐

- ☐ **Hypertension**
- ☐ **Acute Renal Failure**
- ☐ **Chronic Kidney Disease**
- ☐ **Hyperkalemia**
- ☐ **Anemia of Chronic Disease**
- ☐ **Elevated Creatine**
- ☐ **Potassium**
- ☐ _____
- ☐ **Renal Artery Stenosis**
- ☐ **Kidney Stone**
- ☐ **Dialysis**
- ☐ **Kidney Transplant Followup**
- ☐ **Renal Insufficiency**
- ☐ **Protein In Urine**
- ☐ **Diabetes**
- ☐ _____

Appointment Date:_____ Appointment Time:_____

PLEASE SEND MOST RECENT HISTORY, PHYSICAL, LAB WORK, DEMOGRAPHICS AND INSURANCE INFORMATION

Referring Physician Name: _____

Contact Name:_____

Requesting Staff Member Name_____

Comments_____

Contact Number_____

PLEASE RETURN TO US BY FAX 706-227-4086
OR BY SECURE ELECTRONIC METHODS