

**Referral To**  
NEPHROLOGY SPECIALISTS OF OKLAHOMA

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**Please send the following records for the past 12 months.**

1. **Labs** including CBC, Phosphorus, CMP, BMP, UA, Renal function panel.
2. Current Medication list.
3. 24-Hour Urine Creatinine Clearance & Total Protein- requires height & weight
4. Progress Notes- Clinic and Hospital
5. Patient's most recent H&P
6. Kidney Ultrasound, X-ray, CT, and EKG – reports only

Date and Time faxed to NSO \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, \_\_\_\_\_ : \_\_\_\_\_ am pm

**Referring Physician** \_\_\_\_\_ **Contact** \_\_\_\_\_  
Physician Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Reason for Referral** \_\_\_\_\_

**Patient full name** \_\_\_\_\_

Soc Sec № \_\_\_\_\_ DOB \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address, City, St, zip \_\_\_\_\_  
\_\_\_\_\_

Primary insurance \_\_\_\_\_ Effective date \_\_\_\_\_

Claims Address, City, St, zip \_\_\_\_\_

Policy № \_\_\_\_\_ Group № \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name on card \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Card holder's Soc Sec № \_\_\_\_\_ Card holder's date of birth \_\_\_\_\_

**Authorization №** \_\_\_\_\_ **Referral №** \_\_\_\_\_

Authorization Date: \_\_\_\_\_ Thru \_\_\_\_\_ Ref Date \_\_\_\_\_