



# Refer To

## NEPHROLOGY SPECIALISTS OF OKLAHOMA

Fax: ( 918 ) 481-2775 Ph: ( 918 ) 481-2760, option 2

● Please send these records for past 12 months.

1. **Labs including** CBC, Phosphorus, CMP
2. Current Medication list
3. 24-Hour Urine Creatinine Clearance & Total Protein- requires height & weight
4. Progress Notes- Clinic and/or Hospital
5. Patient's most recent H&P
6. Kidney Ultrasound
7. X-ray / 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 No \_\_\_\_\_ DOB \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

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

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

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

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

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

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

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

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



R. Gold, MD, A. D. Udupa, MD, J. Fu, MD, R. J. Azadi, DO, M. Cameron, MD

Appointment Date \_\_\_\_\_ Appointment Time \_\_\_\_\_