METROLINA NEPHROLOGY
ASSOCIATES, PA
THE METROLINA TRANSPLANT CLINIC
THE METROLINA ACCESS CENTER

New Patient Referral Form

This form can also be found at: www.metrolinanephrology.com
Click on "Request a Nephrology Consult"

Reason for Referral: _____

The following are ***REQUIRED*** prior to receiving an appointment: ***Most Recent Office Note, Most Recent Labs Showing Renal Insufficiency(CMP or BMP), Med List and any Renal Imaging (if performed).***

Appointments are scheduled within 48 business hours of receiving all required and/or requested records and information

*********PATIENTS UNDER 18 SHOULD BE REFERRED TO A PEDIATRIC NEPHROLOGIST*********

FAX COMPLETED FORM TO: 704-884-3320 or 704-731-6901 NEW PATIENT PHONE#: 704-884-2421

Schedule Location: □ Randolph □ Arboretum □ Monroe □ Gastonia □ Huntersville □ Mooresville □ Concord □ Salisbury

Schedule with: □ First Available □ MNA MD Preference_____

Referring MD: _____ Referring MD Contact:_____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax:_____ (this will be the # the appt. info. is faxed to)

Patient Information:

****DOES PT REQUIRE AN INTERPRETER?*** **□ NO □YES, Language _____**

Pt. Name: _____ DOB: _____ Sex: _____ Social Security: _____

Address: _____ Apt: _____City: _____ State:_____ Zip:_____

Home# _____ Cell# _____ Work# _____

Insurance Information: Please include legible copy of front and back of all insurance cards.

Primary Insurance Company: _____

Insurance ID #: _____ Group #:_____

Authorization Required: **□ NO □YES, Auth# _____**

Secondary Insurance Company: _____

Insurance ID #: _____ Group #:_____

Authorization Required: **□ NO □YES, Auth# _____**

****PLEASE NOTIFY PATIENT OF APPOINTMENT DATE AND TIME****

SCHEDULED APPOINTMENT INFORMATION BELOW

APPT DATE: _____ APPT TIME: _____

PROVIDER: _____ LOCATION_____