METROLINA
NEPHROLOGY ASSOCIATES

New Patient Referral Form

This form can also be found at:
www.metrolinanephrology.com
Click on "Referral"

Reason for Referral: _____

Important Referral Information:

- **We request prior to scheduling 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 the age of 18 should be referred to a pediatric nephrologist, please**
- ***Please provide a copy of the front and back of the patient's insurance card(s)***

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

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

Schedule with: □ First Available □ MNA MD Preference_____

Referring MD: _____ Referring MD Contact:_____

Referring MD Address: _____

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# _____

Primary Insurance Company: _____

Insurance ID #: _____ Group #:_____

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

Secondary Insurance Company: _____

Insurance ID #: _____ Group #:_____

PLEASE NOTIFY PATIENT OF APPOINTMENT DATE AND TIME

MNA APPOINTMENT INFORMATION

APPT DATE: _____ **APPT TIME: _____**

PROVIDER: _____ **LOCATION_____**

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