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).**
- **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).**

☐ Urgent Referral

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

Schedule Location: ☐ Freedom ☐ Eastway ☐ Providence Park ☐ Monroe ☐ Gastonia ☐ Huntersville ☐ Concord ☐ Salisbury

Schedule with: ☐ First Available ☐ MNA MD Preference_____

Referring MD: Referring MD Contact:_____

Referring MD Address: _____
(this will be the # the appt. info. is faxed to)

Phone: _____ Fax:_____

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 #: _____

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

Secondary Insurance Company: _____

Insurance ID #: _____ Group #:_____

MNA WILL CONTACT PATIENT TO SCHEDULE

MNA APPOINTMENT INFORMATION

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

PROVIDER: _____ **LOCATION**_____

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