PENINSULA KIDNEY ASSOCIATES

NEW PATIENT REFERRAL FROM

PLEASE FAX COMPLETED FORM TO
(757) 251-7470 HAMPTON/DENBIGH • (757) 345-0770 WILLIAMSBURG

Thank you for referring your patient to Peninsula Kidney Associates. To ensure your patient will be scheduled promptly, please provide the office with the following information:

- ☐ Patient Demographics
- ☐ Copy of Patient Insurance Card/Cards
- ☐ Health History Information
- ☐ Authorization/Referral (If Required)
- ☐ 2 Most Recent Progress Notes
- ☐ 2 Most Recent Lab Results
- ☐ Medication List
- ☐ Most Recent X-Ray/Ultrasound (Renal/Abdominal)

REFERRING PROVIDER INFORMATION

Date:________________ ________________Referring Physician Name:____

Office Phone: ___________________________________ Office Fax:____

Office Contact/Referral Coordinator Name:____

PATIENT INFORMATION

REASON FOR THE VISIT:____

Name:____________________________________ DOB:__________________ Sex: Male/Female SS#:______________________

Address:____City:_________________________State:_________Zip:__________

Home Phone:______________________ Cell Phone:_________________________ Work Phone:___________________________

INSURANCE INFORMATION: **<u>Please include a legible copy of the front and back of all insurance cards.</u>**

Primary Insurance Company:____

Insurance ID#:____ Group#:____

Authorization Required? Yes / No Authorization#:____________________________________ #of Visits:__________________

Secondary Insurance Company:____

Insurance ID#:____ Group#:____

Authorization Required? Yes / No Authorization#:____________________________________ #of Visits:__________________

PATIENT APPOINTMENT INFORMATION

APPT Date:________________ APPT Time:____________ PROVIDER:______________________ LOCATION:_______________