



ESRD/Dialysis Referral Form

If this is an urgent matter, please call our office

Patient Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone (_____) _____ Email Address: _____

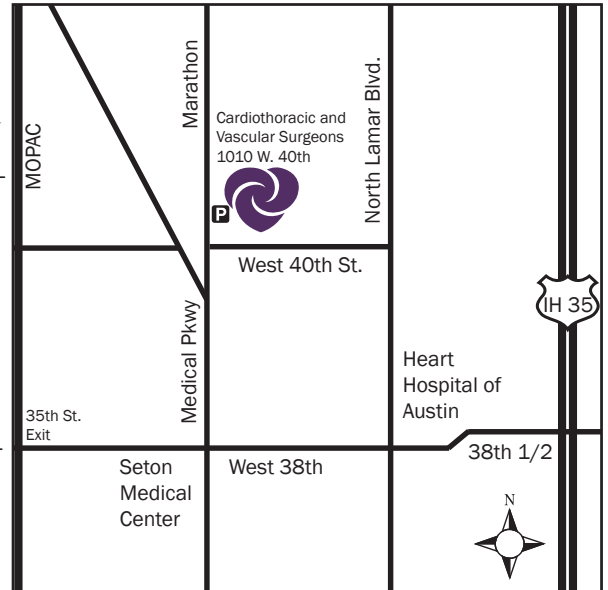
SSN: _____ - _____ - _____ Date of Birth: _____

Nephrologist OR Referring Physician: _____

Is patient in a nursing home? Yes No

Nursing Home Name: _____

Phone (_____) _____



Referral to see:

First Available OR Please check one of the boxes below

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Phillip J. Church, MD | <input type="checkbox"/> Jeffrey S. Jobe, MD | <input type="checkbox"/> Scott A. Seidel, MD | <input type="checkbox"/> David A. Nation, MD |
| <input type="checkbox"/> Mark T. Stewart, MD | <input type="checkbox"/> Stephen M. Settle, MD | <input type="checkbox"/> Jeffrey M. Apple, MD | <input type="checkbox"/> Taylor A. Smith, MD |
| <input type="checkbox"/> John K. Politz, MD | <input type="checkbox"/> Joe K. Wells, MD | <input type="checkbox"/> Mazin I. Foteh, MD | |

Dialysis Information:

Is patient on dialysis? Yes No

If yes, method of dialysis: Fistula/Graft PD Cath Perm Cath

If yes, first date of dialysis: _____

Dialysis Unit: _____ Phone (_____) _____ Contact Name: _____

Dialysis Days: Mon/Wed/Fri Tues/Thurs/Sat Other: _____

Reason for referral:

- Fistula/Graft: Creation OR Problem: _____
- PD Cath: Placement OR Problem: _____
- Permcath: Placement OR Problem: _____
- Other: _____

Please send with all referrals:

- | | |
|-------------------------------|--------------------|
| • Demographics/Insurance | History & Physical |
| • Recent Progress/Office Note | Medication List |

Without the above information, scheduling the patient will be delayed.

Preferred Hospital: _____

When Completed, Please Fax to 512.459.0586