Renal Management Clinic
REFERRAL FORM

Referring Nephrologist:_____ **Date:**_____

Patient Name:_____ **MRN:**_____

PLEASE CHECK IF COMPLETED:

- ❑ CKD confirmed by a Nephrologist (i.e. Reversible causes ruled out)
- ❑ Glomerular filtration rate ≤ 30 ml/min (GFR <10 ml/min will not be accepted)
- ❑ Patient informed of purpose of clinic
- ❑ Accompanying updated detailed **typed** medical history

REFERRAL PROCESS: referral to the clinic must be made by an outpatient nephrologist. Patient's receiving immunosuppressive therapy for GN or transplant will be followed in RMC for CKD management along with f/u by referring MD for management of immunosuppressive therapy.

Patients will not be accepted into the renal management clinic unless above has been completed

INFORMATION REQUIRED

1. **Contact Information**:
   - ❑ Patient telephone numbers (home, work, mobile, alternate contact)
   - ❑ Home address
   - ❑ Emergency contact (name & telephone)
   - ❑ Family/General Practitioner's name/address/telephone/fax
   - ❑ Referring Specialist's name/address/telephone/fax/billing number
   - ❑ Other name/address/telephone/fax (e.g., transplant, homecare coordinator)
2. **Patient Information**:
   - ❑ Name of patient
   - ❑ OHIP number
   - ❑ Date of birth
   - ❑ Languages spoken
   - ❑ Current Height (cm) & Weight (kg)
   - ❑ Current list of Medications and Allergies
   - ❑ 24 hr urine collection for creatinine clearance and proteinuria, completed within 2 months of first appt
3. **Laboratory results** within 1 month of first appointment:
   - ❑ Serum creatinine & urea
   - ❑ Electrolytes
   - ❑ Calcium & phosphorous
   - ❑ PTH
   - ❑ Albumin
   - ❑ CBC
   - ❑ Iron saturation & ferritin
   - ❑ Hemoglobin A1c (if diabetic patient)
   - ❑ Urine: ACR/PCR
4. **Other investigations**, if done within 1 year of first appointment:
   - ❑ EKG, Chest X-Ray, Echocardiogram

Referring Nephrologist's signature: _____

CONTACT
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