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**

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:______________________

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# ______________________

Insurance Information: Please include legible copy of front and back of all insurance cards.

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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