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 5 business days of receiving all required and/or requested records and information**
- **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).**

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:_____

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: _____ Gender: ____ SSN:_____

Address: _____ Apt: _____ City:_____ State: ____ Zip: _____

Home#: _____ Cell#: _____ Work#: _____

Primary Ins. Company: _____ Policy ID/#:_____
Group#: _____

Prior Authorization Required: ☐ No ☐ Yes, Auth# _____

Secondary Ins. Company: _____ Policy ID/#:_____
Group#: _____

********MNA WILL CONTACT THE PATIENT TO SCHEDULE********

MNA APPOINTMENT INFORMATLION

APPT DATE:_____ APPT TIME: _____

PROVIDER: _____ LOCATION: _____