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Vibe Medical Specialists
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NEPHROLOGY REFERRAL FORM

- Patient Name:
- Patient ULI:
- Patient phone number:

Date of Referral:

Referring Physician:

Prac ID:

Clinic Name:

Reasons for Referral:

- ☐ Rapid deterioration in renal function over days to months – on at least two occasions
- ☐ eGFR <30 mL/min/1.73m2 on at least two occasions
- ☐ eGFR 30-60 AND eGFR decline ≥ 10 ml/min/1.73m2 in approximately 1 year
- ☐ Proteinuria with ACR > 30 mg/mmol in non-diabetic or 60 mg/mmol in diabetic on at least two occasions
- ☐ Hematuria
- ☐ Cystic and Hereditary Renal Disease (ex. Autosomal Dominant Polycystic Kidney Disease)
- ☐ Potassium, Sodium or Acid Base Disorders
- ☐ Pregnancy and Chronic Kidney Disease
- ☐ Resistant or suspected Secondary Hypertension
- ☐ Nephrolithiasis Work up
- ☐ Other:

_____

History:

Diabetic: No/ Yes

Hypertension: No/ Yes

Most Recent Blood pressure:

Please include a list of patient medications currently if possible.

Please fax referrals to (780) 496-1387