HealthCare

CLINIC REFERRAL FORM

NEPHROLOGY HYPERTENSION

To make a patient referral, please complete the following form and fax it to **859-257-0260**.

Nephrology, Bone and Mineral Metabolism
135 East Maxwell Street, Suite 401
Lexington, KY 40508
Phone: **859-323-2663** | Fax: **859-257-0260**

Referring Provider Information

Name: _____ Phone: _____ Fax: _____

Patient Information

Full Legal Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____

Insurance Information: (Please provide copies of insurance cards) Interpreter Needed: _____

_____ Preferred Language: _____

Type of Referral: (check all that apply)

- ☐ Consultation for diagnosis
- ☐ Consultation for medication adjustment
- ☐ Long-term management of hypertension

Reason For Referral: (check all that apply)

- ☐ Resistant hypertension
- ☐ Hypertension in pregnancy
- ☐ Concern for secondary hypertension
- ☐ 24-hour ambulatory blood pressure monitor request
- ☐ Hypertension with persistent metabolic abnormalities
- ☐ Hospital follow-up for hypertensive urgency/emergency
- ☐ Hypertension with need for volume management or in setting of end organ damage
- ☐ Other: _____

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Please include documentation of any work-up regarding hypertension your patient has already completed (renin/aldo levels, renal ultrasound, CT/MRI, X-rays, etc).

Please include or list any recent BP readings along with medications that have been tried and failed, along with any side effects.

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