

RENAL MEDICAL ASSOCIATES

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NEW PATIENT REFERRAL FORM

*****Fax the following requested records along with this form for more prompt referral processing*****

- * Please circle a MD name if you are requesting a certain provider
- * Lab reports. At Least 3-4 different reports showing a BMP or CMP, if available.
- * Last 2 Office Notes
- * List of Medications
- * Any radiology images (US, CT, MRI etc.) of the kidney's or abdomen & pelvis
- * Patient Demographic
- * Insurance Cards

**** Please note you will receive a fax notification with appointment information; And once the patient is scheduled and you will need to notify the patient of the appointment.****

Date: _____

Referring Physician: _____ Phone: _____

Contact Person: _____ Fax: _____

Address: _____ NPI: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____

Patient's Name: _____

D.O.B.: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance: _____ ****PLEASE FAX COPY OF CARDS****

Home Phone: _____ Cell: _____ Other: _____

Has the patient ever seen a nephrologist? Yes/No If yes, who?: _____

***** For Our Office Use *****

Appointment Date: _____ Time: _____

New Patient Packet Mailed: _____