Renal and Transplant Associates of New England

100 Wason Ave. Suite 200 Springfield, MA 01107

New Patient Coordinator Department

Tel: (413)234-3434 Fax: (413)855-524-1977

New Patient Referral Form Today's Date: _____

Nephrologist Requested_____

PATIENT NAME	DATE OF BIRTH	HOME PHONE	CELL PHONE
PARENT/GUARDIAN NAME IF APPLICABLE		HOME PHONE	CELL PHONE
RELATIONSHIP TO PATIENT			
REFERRING PHYSICIAN		OFFICE PHONE	OFFICE FAX
OFFICE CONTACT		PHONE	EXTENSION
PRIMARY CARE PHYSICIAN (if different)		OFFICE PHONE	OFFICE FAX

REASON FOR THE REFERRAL (clinical question)	Appt Type: ○ Routine (3-4 weeks) ○ Urgent (24-72 hrs)

TYPE OF SERVICE REQUESTED:	Special Instructions/Medical Precautions
○ Consult Only (evaluate & advice) ○ Complete Transfer of Care ○ Co-management with Shared Care ○ Co-management with Principle Care	

*** **PLEASE FAX THE FOLLOWING INFORMATION ALONG WITH THIS REFERRAL FORM** TO ***

FAX 855-524-1977 OR 413-734-8027

****ANY MISSING INFORMATION WILL RESULT IN A DELAY IN SCHEDULING****

- ○ Demographics & Insurance Information (ID#)
- ○ Recent Office Notes
- ○ Most Current medication List
- ○ Laboratory Result from last 6 months
- ○ Any relevant diagnostic results/imaging (CT/MRI/ Ultrasound etc.)
- ○ Most Recent H & P from PCP
- ○ Hospital D/C summary if within past 6 months
- ○ Insurance Referral (if required) including duration / number of visits

\ROVIDER REFERRAL CONFIRMATION

For Office use only

DATE REFERRAL FORM RECEIVED	APPOINTMENT DATE & TIME	APPT SCHEDULED BY

PROVIDER	LOCATION	RECORDS SCANEND INTO ACUMEN Y ( ) N ( )

REQUEST FOR ADDITIONAL INFORMATION (PLEASE SPECIFY)