



Physician Referral Form

Thank you for referring your patient to Diablo Nephrology. In order for us to provide the best care, please send us this completed form and the information requested to the office circled below. Thank you.

-Diablo Nephrology Medical Group

Patient Name: _____ **Date:** _____

Patient's Date of Birth: _____ **Phone #:** _____

Patient's Insurance: _____

Referring Provider: _____

Phone #: _____ **Fax #:** _____

Reason for Referral: Evaluation and management of *(Check all that pertains)*

- Stage III chronic kidney disease (eGFR 30-59).
- Stage IV chronic kidney disease (eGFR 15-29).
- Stage V chronic kidney disease (eGFR < 15).
- Acute kidney injury.
- Proteinuria.
- Hematuria.
- Edema.
- Renal transplant.
- Polycystic kidney disease.
- Electrolyte abnormality.
- Acid-base disorder.
- Hypertension.
- Anemia of chronic kidney disease.
- Other: _____

In order to provide the best patient care, please fax the following:

1. Patient demographics or face sheet.
2. **Office note.** Please include at least the latest note and H&P.
3. Pertinent **laboratory studies.** Please include at least the **last 3**, if possible.
4. Pertinent **imaging** studies (ie, renal ultrasound).
5. **Medication** list.
6. **Insurance card(s).**
7. **Prior authorization**, if needed.

Walnut Creek Office
110 Tampico, Ste 200
Walnut Creek, CA 94598
Fax: 925-944-1957
Main: 925-944-0351

Concord Office
2222 East St, Ste 305
Concord, CA 94520
Fax: 925-686-8443
Main: 925-686-1230

Antioch Office
2370 Country Hills Dr, Ste 101
Antioch, CA 94509
Fax: 925-779-9672
Main: 925-779-9635