Summit Kidney and Hypertension Care

Phone: (317) 476-2946 | Fax: (833) 455-8852 | Email: info@skidneycare.com
Mirza M Baig, MD, FASN

1. REFERRING PROVIDER INFORMATION

Provider Name: _____ **Practice Name:** _____

Contact Person: _____

Phone Number: _____ **Fax Number:** _____

2. PATIENT INFORMATION

Full Legal Name: _____

Date of Birth: _____ **Phone Number:** _____

Primary Insurance: _____ **Policy ID / No:** _____

3. CLINICAL REASON FOR REFERRAL

[ ] Chronic Kidney Disease (CKD) Stage: ____

[ ] Uncontrolled / Resistant Hypertension

[ ] Electrolyte Abnormality (K, Na, Ca, Mg)

[ ] Acute Kidney Injury (AKI) / Elevated Cr

[ ] Proteinuria / Microalbuminuria

[ ] Hematuria (Gross or Microscopic)

[ ] Kidney Stones (Nephrolithiasis)

[ ] Other / Consultation Request

Specific Clinical Questions / Comments:

_____

_____

4. REQUIRED DOCUMENTATION CHECKLIST (Please attach to this fax)

[ ] Patient Demographics / Face Sheet

[ ] Front & Back of Insurance Card(s)

[ ] Recent Clinical Notes (Last 2 visits)

[ ] Recent Laboratory Results (eGFR, Serum Creatinine, BMP)

[ ] Urinalysis (UA) / Urine Protein-to-Creatinine Ratio

[ ] Renal Ultrasound / Imaging Reports (If applicable)

5. URGENCY & TRIAGE LEVEL

[ ] **URGENT** (Inpatient follow-up / Rapidly declining renal function - *Will be reviewed in 24-48 hours*)

[ ] **ROUTINE** (Chronic management / Next available appointment)

Referring Provider Signature: _____ **Date:** _____