Date received in Renal clinic: _____

Faxed: ____ Pages Renal Fax: 705-759-4999

Expect notification of appointment date within 2 weeks. Please contact ARRP clinic if not received.

Algoma Regional Renal Program Referral Form

PATIENT NAME: _____ D-O-B: _____

Address:_____ Phone:_____

Alternate Contact, as indicated: Name: _____ Phone: _____

INCOMPLETE REFERRALS WILL NOT BE PROCESSED

REQUIRED INFORMATION

1) Summary Letter
2) Allergies
3) Most recent weight
4) Medication record and patient's pharmacy
5) Copy of most recent blood work
6) Referring department/office Fax number

PRIORITY

REFERRING PHYSICIAN: _____

☐ P1: Within two weeks due to demonstrated rapid decline in renal function

✱**All P1 selections require phone confirmation with On-Call Nephrologist**

☐ P2: 4-6 weeks

☐ P3: 6-8 weeks

Time from referral to appointment will vary based on Renal Clinic volumes

CONSULTATION REASON

☐ eGFR values: documented serial eGFR values improve triage of consultation requests

Current Visit _____mL/min **Date** _____ **Previous visit #1** _____ mL/min **Date** _____

Previous visit #2 _____ mL/min **Date** _____

☐ Haematuria - include any Urology consult notes

☐ Hypertension

☐ Nephrolithiasis

☐ Proteinuria/microalbuminuria: most recent value_____

☐ Autosomal Dominant Polycystic Kidney Disease

☐ Other: _____

For Renal Clinic Use:

Appointment Booked: Date_____ Time: _____

Renal Clinic staff confirmed with: Patient □ Yes □ No □ other: _____