Referral Form

Patient Name: ____

Date of Birth: ____

Patient's phone number:____

Patient's Address:____

Insurance:____

Referring office: ____

Referring Provider: ____

Reason for Consult: ____

Thank you for allowing us to partner in treating your patient. In order for us to properly schedule your patient, please answer the following questions and provide the requested records. Delays in receiving the appropriate documentation will hold-up the referral process.

Does the patient have diabetes? ____yes ____No

Does he patient have hypertension? ____yes ____No

Does the patient have protein in their urine? ____yes ____No

Does the patient have blood in their urine? ____yes ____No

Please send a copy of the following records

- Demographics
- Office notes (at least 2)
- Medication List
- Urinalysis
- Chemistry panels including serum creatinine (need several to compare)
- If available Renal Ultrasound, abdominal Ultrasound, CT or MRI of the abdomen and pelvis

Locations and Fax Numbers:

Greenville – 252-317-2092

Washington – 252-317-2092

Edenton – 252-317-2092

Tarboro – 252-317-2092

Ahoskie – 252-317-2092

Windsor – 252-317-2092

New Bern -252-317-2094

Kinston – 252-317-2096

N. Myrtle Becah – 843-663-0283

Morehead City – 252-317-2094

Jacksonville – 910-353-0549

Wilmington – 910-343-8650

Whiteville – 910-642-6635

Supply – 910-754-3186

Goldsboro /Clinton – 919-580-9838