

**REFERRAL FAX TRANSMISSION**

Date: \_\_\_\_\_

To: Desert Kidney Associates

Fax Number : 480-964-7802

Phone Number: 480-834-9039

From: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Regarding Patient: \_\_\_\_\_

DOB: \_\_\_\_\_

**Special Instructions:**

Please schedule the above patient with Dr.\_\_\_\_\_. Attached are the following documents needed to schedule an appointment.

1. Referring Physician NPI: \_\_\_\_\_

2. Reason for Referral:  
\_\_\_\_\_

3. Progress Notes

4. CMP, CBC (labs)

5. 24 hour urine (total protein & creatinine clearances included)

6. Kidney Ultrasound

7. Medication List

8. Copy of Insurance card(s)

9. Referral, if needed

10. Demographics

Thank You.