_____ **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.