

NABEEL GHABRA, M.D.

## Appointment Referral Form

### NEPHROLOGY

**Please complete form and fax to 681-342-3695**

Referral Date: \_\_\_\_\_ Referring Provider: \_\_\_\_\_

Staff Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_ SS#: \_\_\_\_\_

Primary and Secondary Ins: \_\_\_\_\_ M or F

\*Can the patient make their own medical decisions and sign medical consents? Yes No  
(If NO, a legal representative, guardian or medical power of attorney MUST accompany the patient and provide all legal documents)

\*Does this patient's insurance require an authorization to see a specialist? Yes No  
Authorization Information: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

#### Please Note:

- Please include most recent progress notes, lab results, pathology reports, CT reports, and procedure reports.
- Please include any additional information pertinent to this referral
- We will notify the patient by mail and phone of appointment time and date.

Thank you for your referral. Please do not hesitate to call us with any questions or concerns.

Update: 6/27/2019

Office Use Only: Acct # \_\_\_\_\_ Appt. Date & Time: \_\_\_\_\_