

Patient Information (please fill in or affix label):

NAME: _____ DOB: ____/____/____
dd mm yy
 ADDRESS: _____
 PHONE #: _____ HEALTH CARD #: _____
 ALT. CONTACT INFO: _____

Outpatient Nephrology Referral Form

Date of referral: ____/____/____
dd mm yy

Is this a re-referral? ☐ Yes ☐ No

Name of nephrologist seen previously: _____

Please check nephrologist (if preferred):

Kitchener Site

- ☐ Dr. Benaroya ☐ Dr. Gregor
☐ Dr. Jolly ☐ Dr. Vitou
☐ Dr. Rosenstein

Guelph Site

- ☐ Dr. Burke
☐ Dr. Friedman

Recommended Reason for Referral:

- | | |
|---|---|
| <input type="radio"/> eGFR < 30 ml/min/1.73m ² on 2 occasions, at least 3 months apart | <input type="radio"/> Hematuria (> 20 RBC/hpf or RBC casts) |
| <input type="radio"/> eGFR < 45 ml/min/1.73m ² and urine ACR between 30 and 60 mg/mmol on 2 occasions, at least 3 months apart | <input type="radio"/> Resistant or suspected secondary hypertension |
| <input type="radio"/> Rapid deterioration in renal function (eGFR < 60 ml/min/1.75m ² and decline of 5 ml/min within 6 months, confirmed on repeat testing within 2 to 4 weeks on 2 occasions) | <input type="radio"/> Suspected glomerulonephritis/renal vasculitis |
| <input type="radio"/> Proteinuria (urine ACR > 60 mg/mmol on at least 2 of 3 occasions) | <input type="radio"/> Metabolic work-up for recurrent renal stones |
| | <input type="radio"/> Other: |

Additional comments:

Co-morbid Conditions:

- ☐ Diabetes mellitus ☐ Coronary artery disease ☐ Hypertension ☐ Frailty ☐ Peripheral vascular disease
☐ Previous stroke ☐ Cognitive impairment

Lab Values:

Please fill out below if applicable; refer to the ORN KidneyWise Clinical Algorithm for suggested investigations

Date #1: <small>da/mm/yy</small>	eGFR:	Creatinine:	Urine ACR:
Date #2: <small>da/mm/yy</small>	eGFR:	Creatinine:	Urine ACR:
HbA1c:	Hgb:	K ⁺ :	Ca ²⁺ :
PO ₄ ³⁻ :	Albumin:	PTH:	Hematuria (dipstick):

Other (or attach): _____

Current Medications:

Referring practitioner/address/phone/fax:

Referring billing #:

Signature: