RenalCare
Associates, S.C.

FAX TRANSMITTAL

Date: _____

To: RenalCare Associates
Fax: 309-495-5302 Peoria
309-663-7238 Bloomington
309-343-8190 Galesburg
815-431-0799 Ottawa

From: _____
Fax: _____
Email: _____
Phone: _____

Please indicate the best way to contact you back about the referral

TO BE COMPLETED BY REFERRING CLINICIAN OR OFFICE

Patient Name: _____ **Birthdate:** _____

Nephrology Referral:

Reason for Referral: _____

Resistant Hypertension Clinic Referral: Reason for referral (please check below)

- B/P greater than 150 despite medical treatment of 3 or more anti-hypertensive medications
- Patients requiring immediate blood pressure and medication intervention
- New onset hypertension
- Other: _____

Purpose of consult:

☐ To assist with diagnosis and management.
We will manage this patient together

☐ For opinion only
I will manage this patient with nephrology consults as necessary

Urgency:

☐ Elective – within 2 weeks

☐ Urgent – within 24 hours

Please attach a copy of the patient's demographic and insurance information as well as copies of recent progress notes, medication list, lab work and any renal related radiology reports.