MULTI-CARE KIDNEY CLINIC - REFERRAL FORM

Referring Nephrologist: ______________________________ **Date:** __________________________

Patient Name:____ **MRN:**__________________________

Date of Referral to Nephrology Clinic (ORN requirement):______________________________

Date of First Nephrology Consultation (ORN requirement):______________________________

Kidney Failure Risk Equation: = _______________ **(≥ 10% risk of ESKD over 2 years)**

PLEASE CHECK IF COMPLETED:

- ❑ CKD confirmed by a Nephrologist (i.e. Reversible causes ruled out)
- ❑ **ACR and serum creatinine at time of referral MANDATORY** (must have KFRE of ≥ 10% risk of progressing to ESKD over 2 years and/or eGFR<15ml/min). If not in EPR please attached values from outside lab.
- ❑ Patient informed of purpose of clinic
- ❑ Updated detailed **typed** medical history in EPR or attached if not in EPR.
- ❑ Interpreter needed?_______________Language:_______________________________________

REFERRAL PROCESS: Referral to the clinic must be made by an outpatient nephrologist or discussed in full at eHOME. Patients receiving immunosuppressive therapy for GN or transplant will be followed in MCKC for CKD management along with follow-up by referring MD for management of immunosuppressive therapy.

Patients will not be accepted into the Multi-Care Kidney Clinic unless above has been completed

Referring Nephrologist's signature: ______________________________________

CONTACT

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