UB|MD PEDIATRICS

NEW PATIENT REFERRAL FORM

Please complete the following and fax to the Division of Nephrology at 716.323.0292.

Patient Name: _____ DOB: _____/_____/_____

Referring Provider: _____

PMD (if different from above): _____

Phone: _____ Fax: _____

Reason for Referral:

History (Check any that apply and include details):

- ☐ Abnormal blood work: _____
- ☐ Abnormal imaging studies: _____
- ☐ Abnormal urinalysis: _____
- ☐ Elevated BP: _____
- ☐ Patient/Family concern: _____
- ☐ Transfer of care from other nephrologist.
  Diagnosis: _____
- ☐ Second opinion for: _____
- ☐ Other: _____

Additional Comments:

If you need to reach our office, please call 716.323.0140. Thank you for your referral.

Division of Nephrology
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