BlueGrass Renal Care, PSC

Serving Greater Lexington Area

www.bluegrassrenalcare.com

Phone: 859-263-1717 / Fax: 888-502-7513

Patient Referral Form

In order for our physicians to provide you and your patients with the best possible nephrology care, we will need all the medical records and referral/authorization PRIOR to the appointment date. If medical records and referral/authorization are not received prior to the appointment date, the appointment may need to be rescheduled. *Insurance authorization for referral "by primary care office" is required by many carriers like: Wellcare, Coventry, Blue Cross Medicaid, Passport, Humana CareSource, Humana Medicare plans, Any Medicare Advantage plan or private insurance that has a PCP on the card or says it is HMO.*

Please complete form and Fax it to **888-502-7513**. You will receive a response from us within 24 hours.

Referring physician or Patient Preference: ___First Available ___Dr. Ziad Sara ___Dr. Mohamad Al Abed
Please Select office Location: ___ Lexington ___ Georgetown ___ Winchester ___ Irvine ___ Paris

Required Information to schedule Appointment (Please Check if provided):
___ Patient Demographics and Copy of Current Insurance Cards
___ Lab (ie: chemistries especially ***serum creatinine*** (**last 12 months if possible**), CBC, PTH, Vitamin D levels, PTH, Lipid panel, Hgb A1c, thyroid function,…)
___ Radiology Reports Pertaining to Appointment (ie: renal ultrasound/CT/MRI/DEXA)
___ Current Medication List and Allergy list
___ Current Office and Hospital Notes including any pertinent information

Referring Physician Information:
Physician _____ NPI# _____ Contact Person _____
Office Address _____
Phone _____ Fax _____ E-mail _____

Patient Information:
Patient First Name _____ Last Name_____ Date of Birth: ___ /___ /____
Address_____
City _____State _____ Zip_____ Home Phone (___) _____ Cell Phone (___) _____

Please choose Urgency of Appointment:
__ Emergent (1-2 days) __ Urgent (1-2 Weeks) __ Routine (2-6 Weeks)

Reason for Referral and the nature for urgency "if applicable":
_____
_____

Insurance Information:
Insurance Carrier_____ Group/Plan # _____
Policy Holder Name _____Policy Holder DOB_____

Special Requests and Instructions:
_____
_____

"NOTE: APPOINTMENTS WILL NOT BE SCHEDULED UNTIL ALL INFORMATION IS RECEIVED"