New Patient Referral
Hospital Follow-Up Form

The Renal Group
FOR KIDNEY CARE

PATIENT INFORMATION			
Discharge Date:	Facility:		
Referring Physician:		MD / DO	
Address:	City:	State:	Zip
Phone:	Fax:		
Caller's Name:			
Patient's Name:			
Address:	City:	State:	Zip:
Phone: ( )	2nd Phone: ( ) Phone:		
DOB: / /	SS#: / /		
Diagnosis:			
Allergies:			
Insurance 1:	Insurance 2:		
Referral Needed: Y / N	If Yes, Have referring office fax us a copy.		
Referred to: ☐ Dr. Sarac ☐ Dr. Negrette ☐ Dr. Roy ☐ Dr. Shafi			
Location: ☐ Boardman ☐ Youngstown ☐ Salem ☐ Warren ☐ Lisbon ☐ Columbiana			
Appointment: / /	Time: ☐ AM ☐ PM		
Ref Physician's email address:			
Taken By:	Date Taken:		