



Dear Dialysis Facility Staff,

Thank you for referring your patient for dialysis services at Nephrology, Inc.

It is the policy of Nephrology, Inc. to obtain the following information before arrangements can be made:

1. Completed Patient Information Packet
2. Provide enlarged, legible copies of all insurance cards
3. HCFA - 2728 Form
4. Advanced directives (if applicable)
5. Dialysis orders
6. Code status
7. Chest X-ray or PPD (within one year)
8. EKG, if available (within one year)
9. Current medication list
10. Recent history and physical (within 1 year)
11. Most current office note
12. Last 3 dialysis treatment records
13. Lab profiles within the last 30 days
14. HbsAg Status report within 30 days
15. HbsAb Status report within 1 year
16. Current Plan of Care
17. Most recent psychosocial update
18. Most recent dietary assessment
19. Most recent comprehensive assessment

Upon receipt of all the requested information, our Dialysis Intake Coordinator will forward records to the appropriate departments for approval of transfer. A social worker may contact you with questions regarding the transfer of your patient. Once the approval process is complete, our Dialysis Intake Coordinator will notify you confirming dates, times of treatments, and the location of the Nephrology, Inc. facility.

Thank you for your referral to dialysis at Nephrology, Inc.

Sincerely,

Sarah Kazee

Dialysis Intake Coordinator

Phone: (574) 294-4444

Fax: (574) 295-7400

Nephrology, Inc.

700 Waterbury Park Drive

Elkhart, Indiana 46517



Patient Information Packet

Patient Name _____ DOB _____ Sex _____

Marital Status _____ Social Security Number _____

Parent/Legal Guardian _____

Current Address _____

Current City _____ Current State _____ Current Zip Code _____

Current Home Phone _____ Current Work Phone _____

New Address _____

New City _____ New State _____ New Zip Code _____

New Home Phone _____ New Work Phone _____

Date of First Dialysis _____

ESRD Diagnosis: Primary _____ Secondary _____

Emergency Contact _____

Home Phone _____ Work Phone _____

Insurance Information

Primary Insurance _____ Policy Number _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Group Number _____

Secondary Insurance _____ Policy Number _____

Address _____



City _____ State _____ Zip Code _____

Phone Number _____ Group Number _____
**Please include all needed referral information*

Referring Dialysis Facility Information

Referring Facility Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Primary Nephrologist _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

Date of Transfer: _____

Treatment Days Requested (Not Guaranteed) _____

Preferred Time (Not Guaranteed) _____

Special Instructions (Include transplant list information if applicable)

Signature of Person Completing Form _____

Phone Number _____



Release of Confidential Medical Information

The individual(s), whose signature(s) appear below, authorized the release of all requested medical and financial information to Nephrology, Inc., for the purpose of establishing medical care provided by the physicians and staff at Nephrology, Inc.

Patient Name (Printed)

Patient Signature

Date

Parent/Legal Guardian (Printed)

Parent/Legal Guardian Signature

Date