



**KIDNEY SPECIALISTS  
OF SOUTHERN NEVADA**

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## Nephrology Referral Form

Thank you for choosing to refer your patient to KSOSN. To start the referral process, please complete this form and fax it to our Patient Services Department at **(702) 877-7141**.

- Please include all medical records listed below, if available, to expedite the patient scheduling process.
  - Two to three most recent physician evaluations (office notes, hospital H&P, etc.)
  - Last three laboratory results related to the referral
  - All related imaging reports
  - Patient Demographics & all insurance information
  - HMO authorization if required by insurance \*Required

### KIDNEY CONSULT REASON – INFORMATION (Required)

#### Diagnosis/ICD 10

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### REFERRING PROVIDER - INFORMATION

Referring Provider	Specialty
Contact Name	
Phone	Fax

### PATIENT – INFORMATION (Required)

Name	DOB	
Home/Cell Number		
Address		
City	State	Zip
Primary Insurance	ID#	
Secondary Insurance	ID#	

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