Nephrology & Hypertension MEDICAL ASSOCIATES

REQUEST FOR CONSULTATION

Please complete this form and
Fax it to us – see location chart for fax number
Please include one year of office notes, any x-ray/ultrasound reports, labs, list of current medications, and the insurance card

Select Provider Preference: ▢ **No Provider Preference**

▢ Dana Kumjian, MD (GA)
▢ Rebecca Sentman, MD (GA)
▢ Erik Bernstein, MD (GA)
▢ James Bazemore, MD (GA)
▢ Jessica Coleman, MD (SC)
▢ William Gabbard, MD (GA)
▢ Mikhail Novikov, MD (SC)

▢ **STAT** ▢ **Next Available** ▢ **Routine** (no urgency)

Location Preference:

▢ 1115 Lexington Avenue
Savannah, GA 31404
Phone 912/354-4813
Fax 912/354-7569

▢ 16 Kemmerlin Lane
Suite A
Beaufort, SC 29907
Phone 843/524-2002
Fax 843/524-3522

▢ 16 Okatie Center Blvd.
Suite 100
Okatie, SC 29909
Phone 843/706-9955
Fax 843/706-9956

▢ 3025 Shrine Rd.
Ste 450
Brunswick, GA 31520
Phone 912/354-4813
Fax 912/354-7569

PATIENT INFORMATION

Name_____ DOB ____/____/_____ SS #_____-____-_____
(first, middle, last)

Address _____

City _____ State _____ ZIP _____

Parent/Guardian _____

Patient's Day Phone ( ) _____Mobile Phone ( ) _____

Email Address _____

REASON FOR CONSULTATION_____

PRIMARY INSURANCE (or attach insurance card) _____
Policy Holder's Name _____
Group # _____Policy # _____

SECONDARY INSURANCE (or attach insurance card) _____
Policy Holder's Name _____
Group # _____Policy # _____

REFERRING PHYSICIAN INFORMATION

Name _____ Referring Provider's NPI _____

Practice Name _____

Address _____ Phone ( ) _____

City _____ State _____ ZIP_____Fax ( ) _____

Name of Contact Person _____ *Referral # _____ # visits* _____

* must be completed for us to provide an appointment day and time for your patient.

INTEROFFICE USE: Date of Appointment _____ Time _____AM/PM
Location _____ Scheduled by _____Date Scheduled _____
Referring MD notified of appointment? ▢ Yes ▢ No By _____