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**

| Savannah, GA | Beaufort / Okatie, SC | Brunswick / Jesup, GA |
|---|---|---|
| ▢ Dana Kumjian, MD | ▢ Jessica Coleman, MD | ▢ William Grubb, MD |
| ▢ Rebecca Sentman, MD | ▢ Mikhail Novikov, MD | ▢ Bryan Krull, DO |
| ▢ Erik Bernstein, MD | ▢ Jorge O. Chabrier-Rosello, MD | ▢ C. Thomas Tucker, MD |
| ▢ James Bazemore, MD | | ▢ Rafael David Rodriguez, MD |

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

***Location Preference:***

| 1115 Lexington Ave. | 16 Kemmerlin Lane | 16 Okatie Center Blvd S | 3025 Shrine Rd Ste 450 | 111 Colonial Way 2 |
|---|---|---|---|---|
| Savannah, GA 31404 | Beaufort, SC 29907 | Suite 100 | Brunswick, GA 31520 | Jesup, GA 31520 |
| Phone 912/354-4813 | Phone 843/524-2002 | Okatie, SC 29909 | Phone 912/264-6133 | Phone 912/588-1919 |
| **Fax 912/354-7569** | **Fax 843/524-3522** | Phone 843/706-9955 | **Fax 912/267-1415** | **Fax 912/588-1959** |
| ▢ | ▢ | **Fax 843/706-9956** ▢ | ▢ | ▢ |

**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.

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