

# OUTPATIENT CONSULT REQUEST

**Send Form and Records to:**  
 IntMed-Neph-  
 CallCenter@med.umich.edu  
**Or Fax to: 734-998-2516**

**Division of Nephrology**  
 1500 East Medical Center Drive  
 Ann Arbor, MI 48109-0361  
 Office: 888-287-1084  
 Fax: 734-998-2516

Today's Date: \_\_\_\_\_

## Patient Demographic Information

Patient Last Name:		Patient First Name:	
Street Address:	City:	State:	Zip:
Home Phone:		Cell Phone:	
Patient Sex assigned at birth:		Patient Gender:	
Main Contact Name (if not patient):		Main Contact Phone:	
Primary Insurance Company:			
Date of Birth:			

## Physician Information

<b>Referring Physician Name:</b>			
Office Contact Name:			
Address:	City:	State:	Zip:
Phone:		Fax:	
<b>Primary Care Physician Name (if different than referring physician):</b>			
Address:	City:	State:	Zip:
Phone:		Fax:	

**If referring to a specific provider, please note:** \_\_\_\_\_

**SELECT THE PATIENT'S PRIMARY DIAGNOSIS AND ANSWER ANY APPLICABLE QUESTIONS**

*Check appropriate category and make any relevant comments*

	<b>General Nephrology</b> <ul style="list-style-type: none"><li>• Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</li></ul>	<i>Please List Referring Diagnosis / Comments:</i>
	<b>Chronic Kidney Disease (CKD)</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Stage 3 (eGFR 30-59)</li><li><input type="checkbox"/> Stage 4 (eGFR 15-30)</li><li><input type="checkbox"/> Stage 5 (eGFR &lt; 15)</li><li><input type="checkbox"/> Unknown</li></ul> <ul style="list-style-type: none"><li>• Is the patient on dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</li></ul>	<i>Comments:</i>
	<b>Known Glomerular Disease (GD)*</b> <ul style="list-style-type: none"><li>• Is the patient active or in remission? <input type="checkbox"/> Active <input type="checkbox"/> Remission <input type="checkbox"/> Unknown</li></ul>	<i>Please List Referring Diagnosis / Comments:</i>  <i>*This selection is for patients with a confirmed diagnosis of glomerular disease. If this patient does not have a confirmed glomerular disease diagnosis, please refer the patient to "General Nephrology."</i>
	<b>Kidney Stones</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Kidney Stones</li><li><input type="checkbox"/> Medullary sponge disease</li><li><input type="checkbox"/> Other (specify):</li></ul>	<i>Comments:</i>
	<b>Polycystic Kidney Disease (PKD)</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Polycystic Kidney Disease</li><li><input type="checkbox"/> Other Cystic Kidney Disease</li></ul>	<i>Comments:</i>
	<b>Kidney transplant recipient</b>	<i>Comments:</i>