



John C. Maynard, MD
 Charles J. Sweeney, MD
 Krishna Sankaran, MD
 James A. Stim, MD
 Michael Robertson, MD
 Syed Ahmed, MD
 Mashood Ahmad, MD
 Joanna Niemiec, MD
 Bindu Pavithran, MD
 Charlene Murdakes, MD

RNA Consult Request Form

Phone 815-227-8300 Fax 815-227-8301

Consult directions: Please fax this along with the records that have been described below. Once records have been received we will gladly call the patient to set up the appointment. This same form will then be faxed back to the referring office with the pertinent information located at the bottom.

Date _____ Sender's Name _____ Phone# _____

Patient Name _____ DOB _____ Patient Address _____ _____ Home Phone _____ Work Phone _____ Cell Phone _____ SSN _____ Insurance 1 _____ 2 _____ Reason for referral: _____ _____ Recent Labs: Draw Date _____ BUN _____ Cr _____ K+ _____
--

Referring MD/DO _____ Address _____ _____ Phone _____ Fax _____ UPIN # _____ NPI # _____ Is the above Doctor the primary Doctor? Yes _____ No _____ If No: Primary Care Doctor's Name _____ Address _____ Phone _____
--

Please provide the following information if available: <small>(Please fax info along with referral form)</small> Most recent History & Physical Sent _____ Received _____ Most recent Progress notes Sent _____ Received _____ BMP, Hemogram and Urinalysis for the last 12 months Sent _____ Received _____ All Ultrasound/X-Ray of kidneys Sent _____ Received _____ Please list any addition information sent along with any special requests. _____ _____ _____
--

<i>For RNA office use only</i> Spoke w/ Pt _____ Date _____ Time _____ Appt date/time _____ Doctor _____ Location _____ Spoke w/referring office _____ Letter mailed to pt _____ RNA staff signature _____
