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

RNA Consult Request Form

Phone 815-227-8300 Fax 855-243-0207

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+**_______

Gender_________ **Ethnicity**_______________

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:

(Please fax info along with referral form)

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.

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For RNA office use only

*Spoke w/ Pt*______

*Date*___________

*Time*___________

*Appt date/time*______________________

*Doctor*____________________________

*Location*____________________________

*Spoke w/referring office*______________

Letter mailed to pt __________________

*RNA staff signature*__________________