

REGIONAL NEPHROLOGY CLINIC REFERRAL FORM

2200 Eglinton Ave. W., Mississauga ON L5M 2N1
 Phone: 905-813-3951 | Fax: 905-813-3830
 www.trilliumhealthpartners.ca

Patient Information

Patient Acct No.	
<input type="text"/>	
Patient Unit No.	
<input type="text"/>	
Patient Name (Surname First)	
<input type="text"/>	
D.O.B.	Sex
<input type="text"/>	<input type="text"/>
Address	
<input type="text"/>	
City	Postal Code
<input type="text"/>	<input type="text"/>
Health Card Number	Version
<input type="text"/>	<input type="text"/>

- New Referral
 Re-referral

Date of Referral (dd/mm/yy)

Date of last Clinic Note:

Patient's Phone #:

Alternate Contact #:

Please Select (✓) for either urgent, non-urgent or elective and reason for urgency that apply

EMERGENT	Please call Trillium Health Partners, Credit Valley Site locating at (905)813-4466 and ask them to page the Nephrologist on call for consults at Credit Valley Hospital.
URGENT REFERRAL <input type="checkbox"/> (Less than or equal to 4 weeks)	<input type="checkbox"/> Rapid deterioration in renal function (<i>eGFR less than 60 ml/min/1.75m² and decline of 5ml/min within 6 months, confirmed on repeat testing within 2 to 4 weeks on 2 occasions</i>) <input type="checkbox"/> eGFR less than 30 ml/min/1.73 ² on 2 occasions, at least 3 months apart <input type="checkbox"/> Suspected glomerulonephritis/renal vasculitis <input type="checkbox"/> Proteinuria (<i>urine ACR greater than 60 mg/mmol on at least 2 of 3 occasions</i>)
NON-URGENT REFERRAL <input type="checkbox"/> (Less than or equal to 3 months)	<input type="checkbox"/> Proteinuria/with or without Hematuria (<i>urine ACR 30-60 mg/mmol on at least 2 of 3 occasions</i>) <input type="checkbox"/> Resistant or suspected secondary hypertension <input type="checkbox"/> Electrolyte disorder (<i>e.g. hyponatremia, hyperkalemia</i>)
ELECTIVE REFERRAL <input type="checkbox"/> (Less than or equal to 6 months)	<input type="checkbox"/> eGFR less than 45 ml/min/1.73 ² and urine ACR 30 - 60 mg/mmol on 2 occasions, at least 3 months apart <input type="checkbox"/> Metabolic work-up for recurrent renal stones <input type="checkbox"/> Isolated Hematuria (Normal renal function, no proteinuria) (>20 RBC/hpf or RBC casts) <input type="checkbox"/> Other: <input type="text"/>
Co-Morbid Conditions	<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Hypertension <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Frailty <input type="checkbox"/> Previous Stroke <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Other: (<i>Please Specify</i>) <input type="text"/>

IMPORTANT! To appropriately triage your patient please complete the following checklist and **append all results.**

For Non Urgent/Elective Referral if not completed please indicate whether test has been ordered	Completed	Ordered
Spot Urine for ACR or PCR (at least two or more results) **VERY IMPORTANT VALUE (Mandatory)	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis (at least two or more results) (Mandatory)	<input type="checkbox"/>	<input type="checkbox"/>
Serum Urea & Creatinine with eGFR (at least two or more results) (Mandatory)	<input type="checkbox"/>	<input type="checkbox"/>
24-hour urine collection (CrCl, protein)	<input type="checkbox"/>	<input type="checkbox"/>
CBC, HbA1c, Potassium, PTH, Calcium, Albumin, Phosphate	<input type="checkbox"/>	<input type="checkbox"/>
Renal Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>

Please append **MEDICAL HISTORY** (including immunizations) and **CURRENT MEDICATIONS**

Signature of Referring Practitioner:

Billing #: _____

Date: _____

Referring Practitioner (address/phone/fax):

