



Kidney & Hypertension Consultants

Flint

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Shawn Gorkiewicz, DNP

Date: _____

Please Schedule Patient: _____ DOB: _____

Patient Phone Number: _____

For the following:

- | | |
|---|--|
| <input type="checkbox"/> High Creatinine | <input type="checkbox"/> Low GFR |
| <input type="checkbox"/> Proteinuria | <input type="checkbox"/> Diabetic Nephropathy |
| <input type="checkbox"/> Hematuria | <input type="checkbox"/> Renal Insufficiency |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Abnormal Renal Ultrasound |
| <input type="checkbox"/> Glomerulonephritis | <input type="checkbox"/> PCKD |
| <input type="checkbox"/> Other | |

<u>Medical Hx/Symptoms:</u>	<u>Clinical Dx:</u>
<input type="checkbox"/> Recurrent UTI's	<input type="checkbox"/> CKD Stage 1
<input type="checkbox"/> Hematuria	<input type="checkbox"/> CKD Stage 2
<input type="checkbox"/> Edema	<input type="checkbox"/> CKD Stage 3
<input type="checkbox"/> Uncontrolled HTN	<input type="checkbox"/> CKD Stage 4
<input type="checkbox"/> Hyperparathyroidism	<input type="checkbox"/> CKD Stage 5
	<input type="checkbox"/> ESRD
	<input type="checkbox"/> Secondary HTN
	<input type="checkbox"/> SLE
	<input type="checkbox"/> Nephrotic Syndrome
	<input type="checkbox"/> Diabetic Nephropathy

***Requesting Physician:** _____

**Please send the following information with the referral paperwork so we can contact and schedule your patient.

- | | | |
|--|--|--|
| <input type="checkbox"/> Referral paper complete | <input type="checkbox"/> Demographics | <input type="checkbox"/> Any ultrasounds or radiology of the kidneys |
| <input type="checkbox"/> Last 6 months of labs | <input type="checkbox"/> Last 2-3 Clinic Letters | |

* If you would like to know when patient is scheduled please write your fax number
We will fax this back with an appointment date and time.