

PCP Referral Form

Referral Eligibility (all criteria required):

- Has a diagnosis of CKD Stage 3a – Stage 5
- Has a current diagnosis of hypertension or diabetes mellitus
- Currently has established nephrology care or has been referred to nephrology

Urgent

Provider Information		
Provider Name	Date of Referral	
Patient Information		
First Name	Last Name	Date of Birth (MM/DD/YYYY)
Current CKD Stage *Required	Focused Condition *Required <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension	Current Nephrologist *Required <i>(or date referred to nephrology and name)</i>
Contact Person / Relationship	Phone Number / Mobile Number	<i>Patient's primary language (if not English)</i> _____ <input type="checkbox"/> The patient needs an interpreter
<p>All the below services are included with our program, kindly select the services you would like us to focus on with your patient. *Note: Insurance coverage for services vary. MKC will make every effort for all services to be provided to patient.</p> <p><input type="checkbox"/> Healthy Living Coaching (includes Chronic Conditions Education, Medical Nutrition Therapy, Care Management, Behavioral Health Support)</p> <p><input type="checkbox"/> Chronic Conditions Education (i.e. DM/HTN education, Medications Adherence Coaching, etc.)</p> <p><input type="checkbox"/> Medical Nutrition Therapy (CKD Nutrition education and counseling, meal planning, food label reading)</p> <p><input type="checkbox"/> Other (please describe):</p>		
<p>*SPECIFY PATIENT'S NEEDS:</p> 		
<p><input type="checkbox"/> Demographics, ID/Insurance Card, and Clinical Profile <input type="checkbox"/> Medication List</p> <p><input type="checkbox"/> PCP Consult Note and/or Discharge Summary <input type="checkbox"/> Last Progress Note with Medication List</p> <p><input type="checkbox"/> Labs (please include most recent eGFR and serum creatinine values)</p>		

Referring provider's preferred mode of communication/feedback: Fax Elation