CHOC Children's Specialists

Division of Nephrology Consultation Request

Division Phone: 714.509.8324 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Nephrology.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent/Guardian: _____ Parent Phone: _____

Insurance : _____ Parent Cell: _____

1. **Is this an urgent referral?** ☐ No ☐ Yes If YES, requires a physician to physician call to 714-509-8324

Please select diagnosis ***Pre referral work up requirements by diagnosis:***

☐ **Microhematuria** Persistent (3 urinalyses on 3 different occasions)	►CBC ► Renal function panel ► Renal and bladder ultrasound
☐ **Gross Hematuria** **if painful urination, red urine, blood clots refer to *UROLOGY*	► CBC ► Renal function panel ► Renal and bladder ultrasound ► Physical exam (including blood pressure)
☐ **Proteinuria** (If first am urine has proteinuria ≥+1)	► CBC ► Renal function panel ► Renal and bladder ultrasound ► 1st am urine (from home to lab) for random protein, random creatinine
☐ **Acidosis** (with normal anion gap)	► low serum bicarbonate on 2 tests of venous blood
☐ **Cystic Kidneys** (when seen on ultrasound)	► Blood pressure ► CBC ► Comprehensive metabolic panel ► Urinalysis ► Renal ultrasound if none in past 12 months
☐ **Hypertension** (blood pressure above 95% for age, gender, height percentile on three different days)	► CBC ► Renal and bladder ultrasound ► Comprehensive metabolic panel ► Urinalysis ► Cholesterol
☐ **Other**_____	► call for required labs 714-509-8324

To expedite appointment scheduling, please provide the following by FAX 855-246-2329:

- ☐ **This completed form and patient demographics**
- ☐ **Medical records related to the chief complaint including required labs listed above**
- ☐ **Authorizations(CPT: 99245, 81000, 81002 and Z7500 for CAL-Optima), or if not applicable a copy of insurance card**

Referring Provider Name: _____ Phone: _____ Fax:_____

Provider Address:_____ City: _____ Zip: _____

Provider Signature: _____ Date: _____ Time: _____

Updated on 8/19/2016