Reset Form

Trillium Health Partners

REGIONAL NEPHROLOGY CLINIC REFERRAL FORM

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

☐ New Referral
☐ Re-referral

Date of Referral (dd/mm/yy)

Date of last Clinic Note: _____

Patient's Phone #:

Alternate Contact #:

Patient Information

Patient Acct No.

Patient Unit No.

Patient Name (Surname First)

D.O.B. | Sex

Address

City | Postal Code

Health Card Number | Version

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 (Less than or equal to 4 weeks)	☐ Rapid deterioration in renal function *(eGFR less than 60 ml/min/1.75m^2 and decline of 5ml/min within 6 months, confirmed on repeat testing within 2 to 4 weeks on 2 occasions)* ☐ eGFR less than 30 ml/min/1.73^2 on 2 occasions, at least 3 months apart ☐ Suspected glomerulonephritis/renal vasculitis ☐ Proteinuria *(urine ACR greater than 60 mg/mmol on at least 2 of 3 occasions)*
☐ **NON-URGENT** REFERRAL (Less than or equal to 3 months)	☐ Proteinuria/with or without Hematuria *(urine ACR 30-60 mg/mmol on at least 2 of 3 occasions)* ☐ Resistant or suspected secondary hypertension ☐ Electrolyte disorder *(e.g. hyponatremia, hyperkalemia)*
☐ **ELECTIVE** REFERRAL (Less than or equal to 6 months)	☐ eGFR less than 45 ml/min/1.73^2 and urine ACR 30 - 60 mg/mmol on 2 occasions, at least 3 months apart ☐ Metabolic work-up for recurrent renal stones ☐ Isolated Hematuria (Normal renal function, no proteinuria) (>20 RBC/hpf or RBC casts) ☐ Other: _____
Co-Morbid Conditions	☐ Diabetes Mellitus ☐ Hypertension ☐ Peripheral Vascular Disease ☐ Frailty ☐ Previous Stroke ☐ Coronary Artery Disease ☐ Cognitive Impairment ☐ Other: *(Please Specify)*_____

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)	☐	☐
Urinalysis (at least two or more results) (Mandatory)	☐	☐
Serum Urea & Creatinine with eGFR (at least two or more results) (Mandatory)	☐	☐
24-hour urine collection (CrCl, protein)	☐	☐
CBC, HbA1c, Potassium, PTH, Calcium, Albumin, Phosphate	☐	☐
Renal Ultrasound	☐	☐

Please append MEDICAL HISTORY (including immunizations) and CURRENT MEDICATIONS

Signature of Referring Practitioner:

_____

Billing #: _____

Date: _____

Referring Practitioner (address/phone/fax):

6364 D HR (December/2016)