REFERRAL FOR PRE DIALYSIS EDUCATION AND ASSESSMENT

Name:	Referred by:
MRN:	Date:
D.O.B:	
Contact phone numbers:	
Interpreter required: yes no	Language spoken:

Medical History (or attach letter)

Creatinine at referral_____eGFR at referral_____

Dietary intervention

☐ Yes, please specify _____

☐ No, routine screening only

Comments:

General comments

- Attach a copy of recent blood results if the patient is not on the hospital pathology system
- PLEASE advise the patient to make their own appointment by contacting the clinic coordinator on 91133885/4534
- FAX this referral to the Nephrology CNC on 91132808 or send c/- 4 west