REFERRAL FOR PRE DIALYSIS EDUCATION CLINIC

Name: _____ Referred by: _____

MRN: _____ Date: _____

DOB: _____

Address: _____

Contact phone numbers: _____

Interpreter required: Yes No Language Spoken: _____

Renal failure due to: _____

Medical History:

Creatinine at referral: _____ egfr at referral: _____

KFRE at referral: _____2years_____5years

Need to be seen urgently: YES NO

VAN review: YES NO Transplant work-up: YES NO

Preferred RRT from nephrologists opinion: _____

General Comments

_____

_____

_____

_____

_____

- Attach any recent letters and blood results if not found in EMR
- Please fax 9113 1786 / email this referral to kylie.turner1@health.nsw.com.au
- Any questions please contact CKD CNC on 9113 3634