214.366.6060 phone
214.579.6996 fax
www.renaldiseaseresearch.com

RESARCH CONSU LT REQUEST FORM

Patient Name: ____ ____/____/____

Last (Please Print) First DOB

Patient Address: ____

City: ______________________ State: ______________________ Zip: ____________________

Patient Phone: (_______) ____________ Cell: (_______) ____________ Patient Email: ____________________

Language (circle one): English / Spanish / Other ______________________________

Referring Physician Name: ____

Referring Physician/Nurse Signature: ____

Phone #: ______________________ FAX # for Correspondence: ______________________

REASON FOR REFERRAL (please check all that apply)

- ☐ Abnormal Blood Chemistry/Electrolytes
- ☐ Abnormal Kidney Imaging
- ☐ Acute Kidney Injury/Acute Kidney Failure
- ☐ Anemia
- ☐ Chronic Kidney Disease
- ☐ Edema
- ☐ Hypertension
- ☐ Kidney Transplant
- ☐ Nephrolithiasis
- ☐ Nephrotic Syndrome
- ☐ Polycystic Kidney Disease
- ☐ Proteinuria and/or Hematuria
- ☐ General / Not Indicated / Other: ____

Please complete and fax this CONSULT REQUEST FORM to office location below:

PHYSICIAN OFFICE: With Consult Request Form	**PATIENT:** Bring ALL Current Medications,

Renal Disease Research Institute - Dallas Viceroy Office
1420 Viceroy Dr., Dallas, TX 75235
Appt.: 214.366.6060
FAX: 214.579.6912

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