Nephrology & Hypertension MEDICAL ASSOCIATES

# REQUEST FOR CONSULTATION

*Please complete this form and*
*Fax it to us – see location chart for fax number*
*Please include one year of office notes, any x-ray/ultrasound reports, labs, list of current medications, and the insurance card*

***Select Provider Preference:*** ▢ **No Provider Preference**

| Savannah, GA | Beaufort / Okatie, SC | Brunswick / Jesup / St Marys, GA |
|---|---|---|
| ▢ Dana Kumjian, MD | ▢ Jessica Coleman, MD | ▢ William Grubb, MD |
| ▢ Rebecca Sentman, MD | ▢ Mikhail Novikov, MD | ▢ Bryan Krull, DO |
| ▢ Erik Bernstein, MD | ▢ Martin Webb, MD | ▢ Rafael David Rodriguez, MD |
| ▢ James Bazemore, MD | | ▢ Christopher Kolasa, M.D. |

▢ **STAT** ▢ **Next Available** ▢ **Routine** (no urgency)

***Location Preference:***

| | | | | |
|---|---|---|---|---|
| 1115 Lexington Ave.<br>Savannah, GA 31404<br>Phone 912/354-4813<br>**Fax 912/354-7569**<br>▢ | 16 Kemmerlin Lane<br>Beaufort, SC 29907<br>Phone 843/524-2002<br>**Fax 843/524-3522**<br>▢ | 16 Okatie Center Blvd S<br>Suite 100<br>Okatie, SC 29909<br>Phone 843/706-9955<br>**Fax 843/706-9956**<br>▢ | 3025 Shrine Rd Ste 450<br>Brunswick, GA 31520<br>Phone 912/264-6133<br>**Fax 912/267-1415**<br>▢<br>*(Brunswick & St Marys)* | 111 Colonial Way 2<br>Jesup, GA 31520<br>Phone 912/588-1919<br>**Fax 912/588-1959**<br>▢ |

**PATIENT INFORMATION**

Name_____ DOB ____/____/_____ SS #_____-____-_____
(first, middle, last)

Address _____

City _____ State _____ ZIP _____

Parent/Guardian _____

Patient's Day Phone (  ) _____Mobile Phone (  ) _____

**Email Address** _____

**REASON FOR CONSULTATION**_____

**PRIMARY INSURANCE** (or attach insurance card) _____
Policy Holder's Name _____
Group # _____Policy # _____

**SECONDARY INSURANCE** (or attach insurance card) _____
Policy Holder's Name _____
Group # _____Policy # _____

**REFERRING PHYSICIAN INFORMATION**

Name _____ Referring Provider's NPI _____

Practice Name _____

Address _____ Phone (  ) _____

City _____ State _____ ZIP_____Fax (  ) _____

Name of Contact Person _____ *Referral # _____ # visits* _____

* must be completed for us to provide an appointment day and time for your patient.

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INTEROFFICE USE: Date of Appointment _____ Time _____AM/PM
Location _____ Scheduled by _____Date Scheduled _____
Referring MD notified of appointment? ▢ Yes ▢ No By _____