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		☐ Rafael David Rodriguez, MD
☐ James Bazemore, MD		☐ Christopher Kolasa, M.D.

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

Location Preference:

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

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.

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