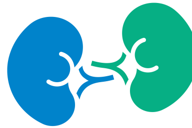
Ontario Renal Network



Please fax the completed referral form to 905-815-9492

Patient Information (please fill in or affix label):

NAME: ______________________ DOB: ___/___/___ (DD MM YY)

ADDRESS: ______________________

PHONE #: ______________________ HEALTH CARD #: ______________________

ALT. CONTACT INFO: ______________________

Outpatient Nephrology Referral Form

Date of referral: ___/___/___ (DD MM YY)

Is this a re-referral? ☐ Yes ☐ No

Name of nephrologist seen previously: ______________________

Recommended Reason for Referral:

- ◯ eGFR < 30 ml/min/1.73m^2 on 2 occasions, at least 3 months apart
- ◯ eGFR < 45 ml/min/1.73m^2 and urine ACR between 30 and 60 mg/mmol on 2 occasions, at least 3 months apart
- ◯ Rapid deterioration in renal function (eGFR < 60 ml/min/1.75m^2 and decline of 5 ml/min within 6 months, confirmed on repeat testing within 2 to 4 weeks on 2 occasions)
- ◯ Proteinuria (urine ACR > 60 mg/mmol on at least 2 of 3 occasions)
- ◯ Hematuria (> 20 RBC/hpf or RBC casts)
- ◯ Resistant or suspected secondary hypertension
- ◯ Suspected glomerulonephritis/renal vasculitis
- ◯ Metabolic work-up for recurrent renal stones
- ◯ Other: ______________________

Additional comments:

Co-morbid Conditions:

◯ Diabetes mellitus ◯ Coronary artery disease ◯ Hypertension ◯ Frailty ◯ Peripheral vascular disease

◯ Previous stroke ◯ Cognitive impairment

Lab Values:

Please fill out below if applicable; refer to the ORN KidneyWise Clinical Algorithm for suggested investigations

Date #1: (DD/MM/YY)	eGFR:	Creatinine:	Urine ACR:
Date #2: (DD/MM/YY)	eGFR:	Creatinine:	Urine ACR:
HbA1c:	Hgb:	K^+:	Ca^{2+}:
PO_4^{3-}:	Albumin:	PTH:	Hematuria (dipstick):
Other (or attach):			

Current Medications:

Referring practitioner/address/phone/fax:	**Referring billing #:**
	Signature:

700 Dorval Dr., Unit 710, Oakville, ON L6K 3V3
Tel: 905-815-9283 Fax: 905-815-9492