EAST TENNESSEE MEDICAL ASSOCIATES, P.C.
RENAL & HYPERTENSIVE DISEASES
CLIFFORD F. WIEGAND, M.D. MARTIN Q. TRAN, D.O. LARA W. KFOURY, M.D.

NEW PATIENT REFERRAL FORM

Forms with missing information may not be considered for scheduling.

PATIENT NAME:	
PATIENT DOB:	SSN:
HOME PHONE:	
PATIENT ADDRESS:	
PRIMARY INSURANCE CARRIER:	
PRIMARY SUBSCRIBER NUMBER:	
SECONDARY CARRIER:	
SECONDARY SUBSCRIBER NUMBER:	

REQUIRED DOCUMENTATION

-DEMOGRAPHIC SHEET
-TWO YEARS OF LABWORK (Specifically CMP/BMP)
-SUPPORTING URINALYSIS OR 24-HOUR URINE COLLECTION
-MEDICATION LIST

WE ASK THE REFERRING PHYSICIAN OFFICE TO NOTIFY THE PATIENT WITH THE DATE AND TIME.

REASON FOR REFERRAL:	
PRIMARY CARE PHYSICIAN:	
REFERRING PHYSICIAN:	
NPI #:	
CONTACT PERSON:	
OFFICE #:	FAX #:

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