CHOC Children's Specialists

Division of Nephrology Consultation Request

Division Phone: 714.509.8324 CHOC Scheduling Line: 888.770.2462 Fax: 855.246.2329

Thank you for referring your patient to the Division of Pediatric Nephrology.

Patient Information

Does the patient live with someone other than the legal guardian? ☐ No ☐ Yes, relationship________________

Patient Name: ______________________________ Date of Birth: ________ / _______ / __________

Parent/Guardian: ______________________________ Parent Phone: ______________________________

1. **Is this an urgent referral?** ☐ No ☐ Yes If YES, requires a physician to physician call to 714-509-8324

Please select diagnosis ***Pre referral work up requirements by diagnosis:***

Please select diagnosis	Pre referral work up requirements by diagnosis
➢ **Microhematuria** Persistent (3 urinalyses on 3 different occasions)	► CBC, Renal function panel ► Renal and bladder ultrasound
➢ **Gross Hematuria** **if painful urination, red urine, blood clots refer to *UROLOGY*	► CBC, Renal function panel ► Renal and bladder ultrasound ► Physical exam (including blood pressure)
➢ **Proteinuria** (If first am urine has proteinuria $\geq$+1)	► CBC, Renal function panel ► Renal and bladder ultrasound ► 1st am urine (from home to lab) for random protein, random creatinine
➢ **Acidosis** (with normal anion gap)	► low serum bicarbonate on 2 tests of venous blood
➢ **Cystic Kidneys** (when seen on ultrasound)	► Blood pressure, CBC, Comprehensive metabolic panel ► Urinalysis ► Renal ultrasound if none in past 12 months
➢ **Hypertension** (blood pressure above 95% for age, gender, height percentile on three different days)	► CBC, Comprehensive metabolic panel ► Renal and bladder ultrasound ► Urinalysis ► Cholesterol
➢ **Hydronephrosis: To Urology**	► Refer to Urology
➢ **Other**____________________________________ ____________________________________	

To expedite appointment scheduling, please provide the following by FAX 855-246-2329:

- ☐ **This completed form and patient demographics**
- ☐ **Medical records related to the chief complaint including required labs listed above**
- ☐ **Authorizations (CPT: 99245, 81000, 81002 and Z7500 for CAL-Optima), or if not applicable a copy of insurance card**

Referring Provider Name: ______________________________ Phone: ______________Fax: ____________

Provider Address: ____________________________________ City: ________________ Zip: ____________

Provider Signature: ______________________________ **Date:** ___________

Updated on 2/4/2019