UNC HEALTH | NEPHROLOGY AND HYPERTENSION
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PHYSICIAN REFERRAL FORM

MULTIDISCIPLINARY VASCULITIS GLOMERULAR AND CONNECTIVE TISSUE DISEASES CLINIC REFERRAL

Thank you for choosing UNC Health! We are dedicated to delivering exceptional care to your patients and greatly appreciate your collaboration in this effort. To ensure your patient receives the highest level of expertise from our specialized clinicians in our Multidisciplinary Vasculitis and Connective Tissue Diseases Clinic, we kindly ask you to provide specific information that will help us facilitate this process smoothly. To initiate a referral to one of our specialists, please complete the attached form and fax it, along with any relevant medical records, to the number provided above. Once we receive your referral and accompanying documents, our team will review the request and connect your patient with the most suitable provider. Our scheduling team will then reach out to your patient to arrange an appointment. After your patient's appointment is complete, we will promptly send you the clinic note detailing the results of their visit. If you need to confirm the status of an appointment, please do not hesitate to call us at the number provided above. Thank you for your partnership in providing quality healthcare! **IMPORTANT:** We will gather all pertinent medical records prior to contacting the patient to schedule an appointment. Please provide the best contact information for your office should we need more information. For information regarding a nephrology referral for patients with other kidney disorders, please visit our website: (https://www.med.unc.edu/medicine/nephrology-hypertension/patient-care/referrals/).

Date					
Patient Name					
Patient DOB		Patient Sex		Patient Phone	
Referring Physician					
Referring Office Phone		Referring Office Fax			
Diagnosis/Reason for referral					

Check the appropriate boxes:

☐	Initial consultation	☐	Second opinion				
Is vasculitis/connective tissue disorder/glomerular disorder confirmed?				Yes	☐	No	☐

Diagnosis: _____

How was diagnosis confirmed?	Serology	☐	Biopsy	☐
Is the biopsy available?	Yes	☐	No	☐

Biopsy site(s): _____

Patient to be seen by (choose one or more)	Nephrology	☐	Rheumatology	☐	Pulmonary	☐	

Along with this form, please fax the following documents/information to the fax number provided above:

Patient demographics	Front and back of patient's insurance card
Laboratory values (see table below) for the past 6 months	Imaging study reports (see table below)
Tissue biopsy pathology report (**not** procedure note)	Initial and follow-up clinic visit notes in past 6 months (nephrology and other subspecialties if available)

Imaging Studies	General Laboratory Values	Others	Others
Chest x-ray	CBC with differential	ANA/ENA/dsDNA	ANA/ANCA
CT (chest/abdomen/pelvis)	CMP	C43/C4/cryoglobulin	Anti-GBM
Kidney ultrasound	Urinalysis Urine protein-to-creatinine ratio Urine albumin-to-creatinine ratio	C-reactive protein (CRP) Rheumatoid factor (RF) Erythrocyte sedimentation rate (ESR)	Pathology reports

If your patient needs to be seen urgently, please contact us at 984-974-5706 and one of our nephrologists will be happy to discuss this with you.