GRAND RIVER HOSPITAL

CKD referral must comply with Kidney Wise Clinical Algorithm
Incomplete referrals will be returned

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? O Yes O No

Name of nephrologist seen previously: _____

Please check nephrologist (if preferred)

Kitchener Site

- O Dr. Benaroia
- O Dr. Jolly
- O Dr. Rosenstein
- O Dr. Gregor
- O Dr. Vitou
- O Dr. Wang

Guelph Site

- O Dr. Burke
- O Dr. Friedman

Recommended Reason for Referral:

- O eGFR < 15 ml/min/1.73m^2 on 1 occasion
- O eGFR < 30 ml/min/1.73m^2 on 2 occasions, at least 3 months apart
- O eGFR < 45 ml/min/1.73m^2 and urine ACR between 30 and 60 mg/mmol on 2 occasions, at least 3 months apart
- O 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)
- O Proteinuria (urine ACR > 60 mg/mmol on at least 2 of 3 occasions
- O Hematuria (> 20 RBC/hpf or RBC casts)
- O Resistant or suspected secondary hypertension
- O Suspected glomerulonephritis/renal vasculitis
- O Metabolic work-up for recurrent renal stones
- O Other:

Additional comments:

Co-morbid Conditions:

O Diabetes mellitus O Coronary artery disease O Hypertension O Frailty O Peripheral vascular disease
O Previous stroke O Cognitive impairment

Complete the following most recent values (incomplete will be returned; refer to Kidney Wise Algorithm):

I.e. eGFR: most recent lab value most recent date (dd/mm/yyyy)

Lab values that are asterixed are mandatory *Include all additional lab work from past 12 months*

****eGFR:** ____ ____ **** Creatinine:** ____ ____ ****ACR:** ____ ____

****HbA1c:** ____ ____ **Hgb:** ____ ____ ****K+:** ____ ____ **Ca2+:** ____ ____

PO_4^{3-}: ____ ____ ****Albumin:** ____ ____ **PTH:** ____ ____ **Hematuria(dipstick):** ____ ____

O Attach Medical History (required) **O Attach diagnostic test results (past 12 months required)**

O List or Attach Current Medications:

Referring practitioner/address/phone/fax:

Referring billing #:

Signature:

Kidney Wise Detect + Protect

Fax completed referral form to: ☐ KW Renal Clinic at **519-749-4210**
☐ Guelph Renal Clinic at **519-822-0701**

Ontario Renal Network
Réseau Rénal de L'Ontario

Revised Oct/16