NORTHWEST Kidney Centers

Referral Form for CKD Services

Patient Name _____ **DOB** ____ / ____ / ____
Month Day Year

Physician _____

Interpreter needed? ☐ Yes ☐ No If yes, language: _____

Referring patient for: (check all that apply and fax this form with items listed below)

- ☐ **Choices** dialysis modality class
- ☐ **Eating Well, Living Well** nutrition class
- ☐ **Medical Nutrition Therapy (MNT)** individual nutrition counseling

Information needed for CKD services:

- Patient demographic sheet
- Recent clinic note/labs
- Insurance ID number or card (*for MNT only*)

Fax completed form and records to (206) 292-2163

For MNT referral, please also complete section below

Please check ALL that apply

Renal

- ☐ N18.1 CKD - Stage I
- ☐ N18.2 CKD - Stage II
- ☐ N18.3 CKD - Stage III
- ☐ N18.4 CKD - Stage IV
- ☐ N18.5 CKD - Stage V

Diabetes

- ☐ Type 1
- ☐ Type 2

Transplant

- ☐ Z94.0 Transplant – Kidney (post)

Additional information for dietitian: _____

_____

_____

MD signature _____ **Date** ____ / ____ / ____
Month Day Year