Billings Clinic Nephrology
1st Floor Clinic
2800 N 29th St
Billings MT 59101
Phone: 406-435-1414
Fax: 406-238-2590

Patient Name: _____ **Date of Birth:** _____ **Patient Phone:** _____

Reason for Consult: _____

Referring Provider: _____ **Provider Phone:** _____ **Provider Fax:** _____

NEPHROLOGY REFERRAL GUIDELINES

☐ Labs completed within the last 6 months
☐ Referral Letter from Referring Provider
☐ All Relevant Medical Records
☐
☐

Referring provider signature required: _____ **Date:** _____

Please send referring provider notes, all Nehrology medical records including images and demographics sheet.

Date faxed: _____