New Patient Medical Records

Patient_____ DOB_____

Appointment_____ Doctor_____

Please check:	Initial & Date:
____ Records Reviewed & Approved	_____
____ Records Reviewed & More Information is needed	_____

Requesting Physician_____ Fax_____

The following is needed:

___ Are you requesting a consultation? Yes_____ No_____

___ Recent H&P

___ Current Medication List

___ Last 8 months-1year of Blood Work & Urine Test

___ Last 8 months-1year of Physicians Clinic Notes

___ Any X-rays or Ultrasounds pertinent to the Kidneys

___ Other

Please fax to: Rockwood (509) 363-3008