Viva Real Renal Care

Patient Referral Form

Phone: 815-603-3305. Fax: 505-581-3306. Email: jose.guzmanrdn@vivarealrenalcare.com

Referring Provider Information

Name: _____

NPI Number: _____

Practice/Organization: _____

Phone: _____

Fax: _____

Email: _____

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Insurance Information

Primary Insurance: _____

Policy Number: _____

Secondary Insurance (if applicable): _____

Reason for Referral / Diagnosis (check all that apply)

[ ] Chronic Kidney Disease (CKD)

[ ] Diabetes (Type 1 / Type 2 / Prediabetes)

[ ] Hypertension

[ ] High Cholesterol

[ ] Weight Loss

[ ] Other:

Additional Notes / Instructions:

_____

_____

Consent and Authorization

By submitting this referral, I authorize Viva Real Renal Care to provide nutrition counseling services to the patient listed above and communicate with the referring provider as necessary for care coordination.

Signature: _____

Date: _____