

**Department of Kidney Medicine
Prince of Wales Hospital
Kidney Services Referral Form**



Please complete this form and attach all requested information and any other relevant results and reports.

Referral to

- HTN Clinic Nephrology Clinic AKI Clinic Specific Doctor _____ (please specify)

Patient details

Name _____
Date of Birth _____
Sex Male Female
Title Mr Mrs Ms Miss
Medicare number _____
DVA Number _____
Private Health Insurance _____
Private Health Insurance No. _____

Address _____
Phone _____
Mobile _____
Email: _____

Interpreter required _____
Preferred Language _____

Reason for Referral

- Abnormal kidney function/reduced eGFR
 Albuminuria/Proteinuria
 Haematuria
 BP
 Other

Results (attach)

- EUC/FBC
 UACR/UPCR
 USS
 Other

PMHx

- DM
 CV
 ATN
 Other

Medications (Can be attached) _____
Referral details _____

Send to:

Clinic: Kidney Care Centre,
Parkes Building Level 3 West
Phone: 9382 4442, 9382 4434
Fax: 9382 4413
Email: POWHKidneyOutpatientsClinic@health.nsw.gov.au

OR Nephrology Office
Level 3, High Street Building
Phone: 9382 4473
Fax: 9382 4409

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