NEPHROLOGY ASSOCIATES OF YAKIMA
315 Holton Avenue, Suite 100, Yakima, WA 98902

CONSULTATION REQUEST FORM

Please complete and fax this form to (509) **248-9134**. Please include any recent chart notes and lab reports from the previous six months, renal or abdominal ultrasound/Doppler reports and current medication list.

**** Patients cannot be scheduled without lab work showing kidney function****

Referring Provider_____ Contact Person _____
Office Phone _____ Office Fax _____
Diagnosis _____

PHYSICIAN PREFERENCE (please circle)

J. Hamilton Licht, M.D. **Sajal Kumar, M.D.** **Flordeliza Lilagan, M.D.**

PATIENT INFORMATION

Patient Name _____ Male _____ Female _____

Date of Birth _____ Social Security Number _____

Address _____ City _____ Zip Code _____

Home Telephone _____ Work _____ Cell _____

Fluent Language if not English _____ Need Interpreter Yes ____ No ____

Appointment time preference Morning _____ Afternoon _____

PATIENT INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group # _____

Policy Holder _____ DOB: _____ Relationship _____

Secondary Insurance _____ ID # _____ Group # _____

Policy Holder _____ DOB: _____ Relationship _____

Insurance Auth # _____ Effective Dates _____ Visits _____
(Please be sure auth is made out to the provider you are referring to)

Please notify your patient of their appointment with Dr. _____ on _____ at _____
We will send the patient paperwork to be filled out prior to their appointment.

Please contact our office with any questions at (509) 248-6292