MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

KIDNEY CARE CLINIC REFERRAL FORM

TEL: (416)- 469- 6580 x3037 FAX: (416)-469-6491

Date: ☐ **Routine** ☐ **Urgent**

Patient ID Label

Patient Last Name:	Given Name:	☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:		Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Alternate Number: ( )
Contact Person (Caregiver/Parent/Guardian:	Relationship To Patient:		Telephone Number - Contact Person: ( )
Family Physician:	**Ontario Health Card Number:** Version Code		**Email Address For Virtual Consult:**
Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown	

Required Questions:	PRIVACY: If we call the patient, can we leave a voice message?	☐No ☐Yes
	WSIB: Is this treatment due to a work related injury?	☐No ☐Yes
	American Sign Language interpreter required?	☐No ☐Yes
	Language interpreter required? - specify:	☐No ☐Yes

Referred To:	☐ First Available Appointment ☐ Dr. Miten Dhruve ☐ Dr. Stephen Chow ☐ Dr. Nausheen Siddiqui ☐ Multi-disciplinary Kidney Care Clinic (MCKC) (if eligible)	Referral Date:

Reason For Referral:

IMPORTANT!

Please send all pertinent lab reports.

If you have scheduled any tests, please record the date of the appointment.

Indications for referral for CKD:

- ☐ eGFR < 30 on 2 occasions, at least 3 months apart, or
- ☐ Rapid deterioration in kidney function: eGFR < 45 and decline of > 5 within 6 months in absence of self-limited illness; eGFR must be repeated in 2-4 weeks to confirm persistent decline, or
- ☐ Proteinuria: urine ACR > 60 mg/mmol on at least 2 of 3 occasions, or
- ☐ 5-year KFRE ≥ 5%

Indications for referral for Nephrology:

- ☐ Resistant or suspected secondary hypertension
- ☐ Suspected glomerulonephritis/renal vasculitis, including RBC casts or hematuria (> 20 RBC/hpf)
- ☐ Metabolic work-up for recurrent renal stones
- ☐ Clinically important electrolyte disorder

Lab Values*:				Lab Report Attached? ☐No ☐Yes	
eGFR:	Date:	Creatinine:	Date:	Urine ACR: Date:	HbA1c: Date:
eGFR:	Date:	Creatinine:	Date:	Urine ACR: Date:	Hgb: Date:
K^{+}:	Date:	Ca^{2+}:	Date:	PO_4^{3-}: Date:	
Albumin:	Date:	PTH:	Date:	Hematuria (dipstick): Date:	

Relevant Medical History/ Co-Morbid Conditions :		
☐ Diabetes mellitus	☐ Hypertension	☐ Cognitive impairment
☐ Coronary artery disease	☐ Frailty	☐ Connective tissue disease (eg SLE, RA, vasculitis)
	☐ Peripheral vascular disease	☐ Other:
	☐ Previous stroke	

Medications	Name	Dose	Frequency

Referring Physician:	Physician Name:	Physician email:
	Telephone Number: ( )	Fax Number: ( )
	Physician's Signature:	Billing#:

MGH Appointment Information:	

Ocean by CognisantMD — Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**