WRHN
Waterloo Regional Health Network

Patient Information (please fill in or affix label):

NAME: _____ DOB: ____ / ____ / ____
(dd / mm / yy)

ADDRESS: _____

PHONE #: _____ HEALTH CARD #: _____

ALT. CONTACT INFO: _____

Outpatient Nephrology Referral Form

Date of referral: ____ / ____ / ____ (dd / mm / yy) Is this a re-referral? O Yes O No

Name of nephrologist seen previously: _____

Please check nephrologist ***- if urgent***, always call nephrologist directly

@ Midtown Fax **519-749-4210**

O First available
O Dr. Benaroia
O Dr. Gregor
O Dr. Jolly
O Dr. Rosenstein
O Dr. Sohail
O Dr. Vitou
O Dr. Wang

Guelph Site Fax **519-822-0701**

O Dr. Burke
O Dr. Friedman

Recommended Reason for Referral (*repeating laboratory investigations prior to referral is encouraged*):

O eGFR < 15 ml/min/1.73m^2 on 1 occasion (always call)

O eGFR < 30 ml/min/1.73m^2 on 2 occasions, at least 3 months apart

O eGFR < 45 ml/min/1.73m^2 and urine ACR between 30 and 60 mg/mmol on 2 occasions, at least 3 months apart

O Rapid deterioration in renal function (eGFR < 60 ml/min/1.75m^2 and decline of 5 ml/min within 6 months, confirmed on repeat testing within 2 to 4 weeks on 2 occasions)

O Proteinuria (urine ACR > 60 mg/mmol on 2 of 3 occasions)

O Hematuria (> 20 RBC/hpf or RBC casts)

O Resistant or suspected secondary hypertension

O Suspected glomerulonephritis/renal vasculitis

O Metabolic work-up for recurrent renal stones

O Other:

Additional comments:

Co-morbid Conditions:

O Diabetes mellitus O Coronary artery disease O Hypertension O Frailty O Peripheral vascular disease
O Previous stroke O Cognitive impairment

Complete the following most recent values (incomplete will be returned; refer to Kidney Wise Algorithm):

ex. eGFR: most recent lab value most recent date (dd/mm/yyyy)

*****Lab values with an asterix are mandatory***** *Include all additional lab work from past 12 months*

		Repeat
****eGFR:** ____ _____	**** Creatinine:** ____ _____	**** Creatinine:** ____ _____ ****ACR:** _____ _____
****HbA1c:** ____ _____	Hgb: ____ _____	****K+:** ____ _____ Ca2+: _____ _____
PO_4^{3-}: _____ _____	****Albumin:** _____ _____	PTH: _____ _____ Hematuria(dipstick):____ _____

O **Attach Medical History (required)** O **Attach diagnostic test results (past 12 months required)**

O **List or Attach Current Medications:**

Referring practitioner/address/phone/fax:

Referring billing #:

Signature:

Kidney Wise
Detect + Protect

Fax completed referral form to: ☐ @ Midtown **519-749-4210**
☐ Guelph Clinic **519-822-0701**

Ontario Renal Network
Réseau Rénal de L'Ontario

Revised July 2025