SPRINGFIELD NEPHROLOGY
& ASSOCIATES, INC.

www.springfieldnephrology.com

Update 5/5/16

Dr. David Sommerfeld
Dr. Susan Woody
Dr. Ethan Hoerschgen
Dr. Giselle Kohler
Dr. Kristie Jones

New Patient Referral Form

(All areas must be completed to process)

Patient Name: _____

DOB _____ **SS#** _____ **Male or Female**

Ethnicity: (please circle) Caucasian African American Other: _____

Address _____ **City** _____ **ST** _____ **Zip** _____

Phone # _____ **Cell/Work #** _____ **Email** _____

Insurance _____ **Policy #** _____

Group # _____ **Insurance Precertification #** _____

Referral Diagnosis (reason for referral must be completed to process) _____

***Most** **new Patient appointments must be seen at the Springfield office for the first visit unless notified with availability. Our outlying clinics are for follow up visits but are not guaranteed. We offer clinics on a first come first serve basis for follow up appointments**.

PREFERED OFFICE IF AVAILABLE? CIRCLE ONE; SPRINGFIELD BOLIVAR LEBANON WEST PLAINS MTN GROVE AURORA

Must be completed

Ref Physician _____ **NPI #** _____
***** Please list Doctor only, no Nurse Practitioners/Physicians Assistants/Mid-level can be used to refer a New Patient*****

Contact Person @ referring Dr. office _____ **Phone #** _____

Ref Dr. Phone #_____ **Fax #** _____

Patient's PCP (if different) _____

Please note: All areas must be complete including contact person information.
All records must accompany New Patient Referral Form to expedite scheduling.
Please fax to (417)886-4725.

We will schedule the patient as soon as possible; we will fax you the appointment date and time.

Thank you, if you have any questions please contact us at (417)886-5000.

Springfield Nephrology office use only:

Appt Date: _____ **Time:** _____ **Dr.** _____

Location: _____ **Acct #:** _____ **Notified:** _____