Acute Kidney Injury (AKI) Follow-up Clinic Referral Form

Date of Referral: ____________  ____________  Staff MD/NP: ______________________

Referral Source:
- ☐ Internal medicine
- ☐ CV surgery
- ☐ Cardiology
- ☐ Nephrology
- ☐ Other: ____________________________________

Dialysis required: ☐ Yes  ☐ No
If Yes:  ☐ CRRT  ☐ SLED  ☐ IHD  ☐ Unknown

ICU stay:  ☐ Yes  ☐ No

Nephrology consults involved: ☐ Yes  ☐ No

Does patient have an outpatient nephrologist:  ☐ Yes  ☐ No

Baseline creatinine: ____________________  or  ☐ unknown

Expected date of hospital discharge: ____________________________________________________

Additional details:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Fax consultation request to—416-867-3709
AKI clinic secretary—416-867-7460 (ext. 8209)

All AKI clinics are held on 61 Queen Street, 9th floor. The target appointment date is within 30 days of hospital discharge, unless otherwise requested