OPTIMA KIDNEY CARE

Referrals may be faxed to 503-714-9620 or emailed to referrals@optimakidney.com
For questions, please call 503-749-9939

Referral Intake Form

Patient Demographics

Name:*

Date of Birth:*

Sex:

Phone Number:*

Address:

City/State/ZIP:

Insurance (Primary):

Policy/ID #:

Insurance (Secondary):

Reason for Referral (check all that apply)

- ☐ Chronic Kidney Disease (CKD) – Stage:
- ☐ Hypertension
- ☐ Kidney Stones (Nephrolithiasis)
- ☐ Proteinuria / Albuminuria
- ☐ Polycystic Kidney Disease (PKD)
- ☐ Other:

Referring Provider Information

Referring Provider Name:*

Practice / Clinic Name:*

Phone:*

Fax:

Email:

Please attach: Recent labs (BMP, CBC, UA, UPCR, A1c if diabetic); imaging reports; recent clinic notes.