Optima Kidney Care – Referral Intake Form

Referring Provider: Please complete and fax/email this form with relevant medical records, labs, and imaging.

Patient Demographics

Name: _____

Date of Birth: ____ / ____ / _____ Sex: ■ Male ■ Female ■ Other

Phone Number: _____

Address: _____

Insurance Information

Primary Insurance: _____

Policy/ID #: _____

Secondary Insurance: _____

Reason for Referral (please 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 (optional): _____

Additional Notes / Pertinent History

_____

_____

_____

Please attach:

- Recent labs (BMP, CBC, urinalysis, urine protein/creatinine ratio, A1c if diabetic)
- Imaging reports (renal ultrasound, CT if applicable)
- Recent clinic notes

Optima Kidney Care – Dr. Marilia Campos
Nephrology Clinic | Sherwood, Oregon | Telehealth available statewide

Fax: _____ | Phone: _____ | Email: _____