Date _____ Camp _____I D No._____

Referral Form for CKD Evaluation

Name _____Age_____M/F_____

Address_____

_____

_____Tel_____Mobile_____

Diabetic ☐ Yes ☐ No If Yes, Years / Months _____

Tabs _____ Yrs / Mts _____

Insulin _____ Yrs / Mts _____

Hypertension ☐ Yes ☐ No

Medications:_____

_____

Cholesterol ☐ Yes ☐ No _____

Eye check up Please (✔)

Retinopathy ☐ No

Hyper tensive ☐ Yes ☐ No Diabetic ☐ Yes ☐ No

Referring Reasons Please (✔)

☐ Diabetic > 5 yrs ☐ HBP uncontrolled (>160/100)

☐ Presence of Urine Albumin ☐ RBC ☐ WBC

To be filled By the Nephrologist

Wt	Ht	BP	GPE
Hb	Chol	Bu	Cr
Urine RE	FBS	e - GFR	BMI

*Appointments may be taken for free CKD evaluation please contact 0484 4011344 between **08: 30 am to12: 30 pm** (time and place of check up will be given then)*

This form is valid only for one month from the date of camp.