

# Referral Form

**METRO ATLANTA  
ACCESS CENTER, LLC**

Dialysis Days: Mon,Wed,Fri / Tue,Thur,Sat

Today's date: \_\_\_\_-\_\_\_\_-20\_\_\_\_

**PLEASE PRINT ALL INFORMATION**

Is patient a resident of a nursing home? No  Yes  If "Yes", please use nursing home address and phone number (below).

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone No.: \_\_\_\_-\_\_\_\_-\_\_\_\_

Last Dialysis Treatment: \_\_\_\_-\_\_\_\_-\_\_\_\_

**Access Type:**

AV Graft /  AV Fistula     Catheter

Date of Creation: \_\_\_\_-\_\_\_\_-\_\_\_\_

Location:     Right /  Left     Forearm /  Upper Arm     Chest /  Thigh

Desired Procedure:     Declot     Fistulogram/Graftogram     Venogram     Other \_\_\_\_\_

Indication:     Clotted Access     Steal Syndrome     Non Maturing Fistula  
 Infiltration     High Venous Pressure     Transonic Monitoring  
 Prolonged Bleeding     Difficult Cannulation     Follow-up  
 Recirculation     Swollen Extremity     Aneurysm

**Catheter Procedure:**

Site:     Tunneled /  Non-Tunneled     Right /  Left     I J /  Groin     Subclavian

Date of Insertion: \_\_\_\_-\_\_\_\_-\_\_\_\_

Desired Procedure:     Insertion     Catheter Change     Removal

Indication:     Clotted Catheter     Poor Function     Infection  
 Broken Catheter     No Longer Required     Other \_\_\_\_\_  
 Exchange temporary catheter for permanent catheter

**Clinical Information:**

X-Ray Contrast Allergy? .....  Yes     No     Reaction? \_\_\_\_\_

Diabetic? .....  Yes     No

Coumadin/Other Lytics? .....  Yes     No

Competent to Sign Consent? .....  Yes     No ..... If "No", Whom? \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_

**Transportation Needs:**

Does Patient have own transportation?     Yes     No

Company \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Ambulatory     Cane     Walker     Wheelchair     Stretcher

Access Center Arranged Transport: Company \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_ Initials \_\_\_\_\_

Post-procedure Destination:     Home     Dialysis Clinic     Other \_\_\_\_\_

**Dialysis Center:**

\_\_\_\_\_  
Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Fax: \_\_\_\_-\_\_\_\_-\_\_\_\_

Scheduled by: \_\_\_\_\_ Nephrologist: \_\_\_\_\_ Surgeon: \_\_\_\_\_

**Insurance Info:**

Patient D.O.B: \_\_\_\_-\_\_\_\_-\_\_\_\_ Patient S.S.N.: \_\_\_\_-\_\_\_\_-\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

**Metro Atlanta Access Center, LLC • 3885 Princeton Lakes Way, Suite 314 • Atlanta, GA 30331  
Phone: 404-349-7770 • Fax: 404-349-7778**

For access center use only. Appointment Date/Time: \_\_\_\_-\_\_\_\_-20\_\_\_\_ @ \_\_\_\_:\_\_\_\_ Pickup Time: \_\_\_\_:\_\_\_\_ Confirmed By: \_\_\_\_\_