

Referral Form

**LOS ANGELES VASCULAR
CENTER**

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:

**Los Angeles Vascular Access Center • 323 North Prairie Avenue • Suite 114 • Inglewood, CA 90301
Phone: 310-674-9300 • Fax: 310-674-9301**

For access center use only. Appointment Date/Time: ____ - ____ -20____ @ ____:____ Pickup Time: ____:____ Confirmed By: _____ WEB