

# Referral Form

## INTERVENTIONAL NEPHROLOGY SPECIALISTS ACCESS 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 /  ThighDesired 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     RemovalIndication:  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     NoCoumadin/Other Lytics? .....  Yes     NoCompetent 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) &amp; Medication List to:

**Interventional Nephrology Specialists Access Center • 2200 Union Avenue • Memphis, TN 38104  
Phone: 901-726-1130 • Fax: 901-726-1132**

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