

Referral Form

SAN DIEGO VASCULAR 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) & Medication List to:

San Diego Vascular Access Center • 5854 El Cajon Blvd. • San Diego, CA 92115

Phone: 619-582-4490 • Fax: 619-582-4737

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