

# Referral Form

EL PASO KIDNEY 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 /  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", by 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:

**El Paso Kidney Specialists Access Center • 11989 Pellicano Drive, Suite D • El Paso, TX 79936**

**Phone: 915-855-9991 • Fax: 915-855-9996**

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