

Referral Form



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:
Greater Dayton Vascular Center • 2016 Springboro West • Dayton, OH 45439
Phone: 937-298-6777 • Fax: 937-298-6716

For access center use only. Appointment Date/Time: ____ - ____ -20____ @ ____:____ Pickup Time: ____:____ Confirmed By: _____
PLEASE ATTACH ANY PREVIOUS PROCEDURES ALONG WITH ALL OTHER PATIENT INFORMATION