

Referral Form

NEPHCON 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:

NEPHCON Vascular Access Center • 1311 Memorial Parkway N.W. • Suite 300 • Huntsville, AL 35801-5903**Phone: 256-535-5008 • Fax: 256-535-2476**

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