

Colorado Renal Access and Imaging Center Referral Order Form

Dialysis Days (circle one): MWF / TTS Dialysis Chair Time _____ Today's Date _____ 20____

Last Dialysis Treatment _____ Are they to return after procedure? YES ____ NO ____
Is patient a resident of a nursing home? Yes ____ No ____ If "yes", please use nursing home address and phone number

Patient Name _____ Patient Phone Number _____

Patient Address _____ City _____ Zip _____

Please Circle Your Answers:

Access Type:

AV Fistula	AV Graft	Catheter
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Location:

Right	Left	Forearm	Upper Arm	Thigh	IJ
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Desired Procedure:

Office Exam	Venous Mapping	Venogram	Fistulogram
Thrombectomy	Catheter Placement	Catheter Exchange	Catheter Removal

Indication (You may circle more than one):

Pain	Swelling	High Venous Pressure	Infiltration	Prolonged Bleeding
Cath. Poor Function	Clotted Access	Difficult Cannulation	Infection	Non-Mature Fistula
Broken	Steal Syndrome	No Longer Required	Aneurysm	↓KT/V
Other (Note details)				

*******REQUIRED PAPERWORK:** Please fax completed Referral Order Form with the following information:
Demographic sheet, medication list, and the Physician's Comprehensive Note (located in Falcon). *****

Clinical Information:

- Contrast Dye Allergy? Yes ____ NO ____ If "yes" please pre-medicate with Prednisone per protocol.
- Diabetic? Yes ____ NO ____ If "yes" please educate patient about insulin and fasting.
- Coumadin Yes ____ NO ____ If "yes," INR _____ Date Drawn _____
- Competent to Sign Consent? Yes ____ NO ____ If "NO," Name & Phone # of MPOA _____
- Hepatitis Status _____

Transportation Needs:

Name of person transporting the patient? _____ Phone Number: _____

Mode of Transport:

Wheelchair	Motorized Wheelchair	Ambulatory	Cane	Walker	Stretcher	Hoyer
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Dialysis Center _____ Phone # _____ Fax # _____

Physician ordering to evaluate and treat: Nephrologist _____ Surgeon _____

Referral Completed by: (Verbal Order – Nurse) _____

Insurance Information:

Patient DOB _____

Primary Insurance _____ Policy # _____ Group # _____

Secondary Insurance _____ Policy # _____ Group # _____

Colorado Renal Access and Imaging Center
130 Rampart Way, Suite 300A, Denver, CO 80230 Phone # 303-343-4244 Fax# 303-343-7563

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