



Referral Form

7633 East Jefferson Ave, Suite 330
Detroit, Michigan 48214
Phone: 313-823-5338
Fax: 313-823-5950

Patient: _____

Date: ____ / ____ / 20____

DOB: ____ / ____ / ____

Does patient have transportation? YES/NO

SSN: ____ / ____ / ____

Mobility: [] Ambulatory [] Wheelchair

Phone Number: (____) ____ - ____

[] Stretcher [] Cane/Walker

Nursing Home patient: YES / NO

Nursing Home: _____

Dialysis days: MWF / TThSat

Last Dialysis Treatment:

Completed Treatment?

____ / ____ / 20____

YES/ NO

Access Type:

[] AV Fistula / [] AV Graft

[] Catheter: [] Removal [] Insertion [] Exchange

Location: [] Left Forearm [] Right Forearm
[] Left Arm [] Right Arm
[] Left Thigh [] Right Thigh

[] Left Chest / [] Right Chest
[] Left Thigh/ [] Right Thigh

Indications: [] Clotted Access [] Aneurysm
[] Prolonged bleeding [] Swelling/Infiltration
[] Decreased K t/v [] Pain
[] Non Maturing Fistula
[] Difficult Cannulation
[] Vessel Mapping

[] Poor Flow [] Clotted Catheter
[] Abnormal Surveillance
[] Infection
[] Broken Catheter
[] Exposed Cuff

Other: _____

Infection Control: [] HEP-C / HIV [] MRSA

Pertinent Information:

[] VRE [] Bed Bugs

*Coumadin/ Other Blood Thinners? YES/ NO

[] C-DIFF [] Head Lice

*X-Ray Contrast Allergy? YES/ NO

*Competent to sign owns consent? YES / NO

Dialysis Center Information:

Dialysis Unit: _____

Nephrologist: _____

Vascular Surgeon: _____

Referring Physician's Signature, if available: _____

Referral Completed by: (Verbal Order – Nurse) _____

*TO EXPEDITE SCHEDULING -PLEASE FAX COMPLETED REFERRAL FORM; PATIENT DEMOGRAPHIC FORM; MOST CURRENT HOME MEDICATION LIST; MOST RECENT LAB VALUES AND LAST TREATMENT SHEET TO

(313) 823 - 5950