Referral Form

LOS ANGELES VASCULAR 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", 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.: _____

Referring Physician's Signature, if available:_____

Referral Completed by: (Verbal Order – Nurse) _____ **Date**:_____

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

Los Angeles Vascular Access Center ● 323 North Prairie Avenue ● Suite 114 ● Inglewood, CA 90301
Phone: 310-674-9300 ● Fax: 310-674-9301

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