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Date: _____

REFERRAL FORM

Appt. Date/Time _____ @ _____

Patient Name: _____

Phone No. _____

Dialysis Unit: _____

Dialysis Unit Phone () _____

Nephrologist: _____

Dialysis Unit Fax () _____

Transportation Schedule : _____

Phone No. _____

Person Completing Form: _____ Dialysis Schedule M/W/F ____ T/TH/S ____

Access Site

Location: Left ____ Right ____
Forearm ____ Upperarm ____ Thigh ____ Jugular ____ Femoral ____ Other _____

Access Type

Fistula/Graft ____ Catheter ____ No existing access ____

Procedure (Required)

Catheters:
__ Exchange
__ Placement
__ Removal
__ Repair

__ Angiogram/ Angioplasty
__ Thrombectomy
__ Vessel Mapping
__ Ultrasound

Other _____

Indication (Required)

__ Poor Flow
__ Prolonged Bleeding
__ Poor Clearances
__ Difficult Cannulation
__ Pain
__ Broken clamp

__ Clotted Access
__ Infected Access
__ Non-Maturing Fistula
__ Mature Access
__ Pulling Clot
__ No existing Access

__ High Venous Pressure
__ Abnormal Arterial Pressure
__ Aneurysm
__ Swelling
__ Abnormal Transonic
__ No Longer Needed

Insurance Information

Patient D.O.B _____ SSN _____
Primary Insurance _____ Policy No. _____
Secondary Insurance _____ Policy No. _____

Referring Physician's Signature, if available: _____

Referral Completed by: (Verbal Order – Nurse) _____

**Patient must bring I.D. and Insurance card(s).
Nothing to eat or drink after midnight. Driver needed if sedation is given.**