TIDEWATER VASCULAR ACCESS CENTER
814 KEMPSVILLE RD, SUITE 101 NORFOLK, VA23502
PHONE: 757-455-8512 FAX : 757-455-8516

PATIENTS REFERRAL FORM

DIALYSIS DAYS: M T W T F (PLEASE CIRCLE)

DIALYSIS: _____PH _____FAX _____

PATIENT'S NAME: _____ DOB _____ PH _____

NEPRHOLOGIST: _____

FORM COMPLETED BY **(VERBAL ORDER – NURSE)** _____

REFERRING PHYSICIAN'S SIGNATURE, IF AVAILABLE:_____

TYPE OF INSURANCE: _____

PLEASE MARK THE TYPE OF SERVICE AND INDICATION

TYPE
- o AV GRAFT
- o AV FISTULA
- o HERO GRAFT
- o CATHETER

LOCATION
- o RIGHT ARM
- o LEFT ARM
- o THIGH
- o CHEST

PROCEDURE
- o VENOGRAM
- o FISTULAGRAM
- o ANGIOGRAM
- o CATHETER REMOVAL
- o CATHETER PLACEMENT
- o CATHETER EXCHANGE
- o THROMBECTOMY (DECLOT)

ULTRASOUNDS
- ❖ VEIN MAPPINGS
- ❖ RENAL US
- ❖ BLADDER
- ❖ PVL LOWER EXTREMITIES
- ❖ PVL UPPER EXTREMITIES

INDICATION
- o CLOTTED ACCESS
- o PROLONGED BLEEDING
- o RECIRCULATION
- o STEAL SYNDROME
- o HIGH VENOUS PRESSURE
- o DIFFICULT CANNULATION
- o SWOLLEN EXTREMITY
- o NON-MATURING FISTULA
- o TRANSONIC MONITORING
- o ANEURYSM
- o NO LONGER REQUIRED
- o INFECTION
- o POOR FUNCTION
- o BROKEN CATHETER
- o PAIN
- o DECREASED KT/V
- o OTHER _____

ALLERGIES
- ➢ XRAY CONTRAST
- ➢ REACTIONS _____

BLOOD THINNERS
- ➢ YES _____
- ➢ NO