

Referral Form

Metropolitan Access Center

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) _____

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

Metropolitan Access Center • 4155 Bladensburg Road • Colmar Manor, MD 20722
Phone: 301-277-1545 • Fax: 301-277-1544

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