Referral Form

ADVANCED ACCESS MEDICAL CARE

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 O Yes O If "Yes", please use nursing home address and phone number (below).

Patient Name: _____

Patient Address: _____

Patient Phone No.: _____-_____-_____ Last Dialysis Treatment: ____-____-_____

Access Type: o AV Graft / o AV Fistula o Catheter Date of Creation: ____-____-_____

Location: o Right / o Left o Forearm / o Upper Arm o Chest / o Thigh

Desired Procedure: o Declot o Fistulogram/Graftogram o Venogram o Other _____

Indication: o Clotted Access o Steal Syndrome o Non Maturing Fistula
o Infiltration o High Venous Pressure o Transonic Monitoring
o Prolonged Bleeding o Difficult Cannulation o Follow-up
o Recirculation o Swollen Extremity o Aneurysm

Catheter Procedure:

Site: o Tunneled / o Non-Tunneled o Right / o Left o I J / o Groin o Subclavian o PD

Date of Insertion: ____-____-_____

Desired Procedure: o Insertion o Catheter Change o Removal

Indication: o Clotted Catheter o Poor Function o Infection
o Broken Catheter o No Longer Required o Other _____
o Exchange temporary catheter for permanent catheter

Clinical Information:

X-Ray Contrast Allergy? ..... o Yes o No o Reaction? _____

Diabetic? ..... o Yes o No

Coumadin/Other Lytics? ..... o Yes o No

Competent to Sign Consent? ..... o Yes o No ..... If "No", Whom? _____ Phone: _____-_____-_____

Transportation Needs: Does Patient have own transportation? o Yes o No

o Company _____ Phone _____-_____-_____

o Ambulatory o Cane o Walker o Wheelchair o Stretcher

o Access Center Arranged Transport: Company _____ Phone _____-_____-_____ Initials _____

Post-procedure Destination: o Home o Dialysis Clinic o 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:

Advanced Access Medical Care | 1733 Eastchester Road, Suite 2 | Bronx, NY 10461
Phone: 718-409-2007 | Fax: 718-409-3374

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