**Anwar Gerges, M.D.**

# REFERRAL FORM

Today's Date: ________ Requested Procedure Date: _________________________
Patient Name: _____________________ DOB__________ Telephone: ___________
Street Address: ____________________
City: ________________ State:_________________ Zip code:____________
Patient's Primary Language:__________________________

**Access Type:**
❑ AV Graft
❑AV Fistula
❑ Other

**Location:**
❑Right
❑Left
❑Forearm
❑Upper arm
❑Other________

**Indication:**
❑Clotted Access
❑Prolonged Bleeding
❑Infiltration
❑Difficult Cannulation
❑High Venous Pressures
❑Transonic Monitoring
❑Low Access Flow Rate
❑Recirculation
❑Aneurysm
❑Swollen Extremity
❑Non-maturing AVF
❑Steal Syndrome

**Desired Procedure**
❑ Thrombectomy (declot)
❑ Fistulogram/Graftogram
❑ Collateral vein ligation
❑ I.V. Vein Mapping

---

**Catheter procedure**
❑ Tunneled
❑ Non- Tunneled
❑ Medi-Port Placement

**Location:**
❑ Right
❑ Left

**Indication:**
❑ Clotted Catheter
❑ Poor Function
❑ Infection
❑ Broken Catheter
❑ No Longer Required
❑ Exchange Temporary

**Desired Procedure**
❑ Declot
❑ Fistulogram/Graftogram
❑ Collateral vein ligation
❑ I.V. Vein Mapping
❑ Other

---

**Clinical Information**
Is the patient taking any Blood Thinners: Aspirin, Plavix, Coumadin, Pradaxa, Lovenox, etc.? ❑ Yes ❑ No
Known allergy to Contrast, Iodine, and Shellfish? ❑ Yes ❑ No List Other Allergies:_________________
Explain Reactions:
Referring Physician: _________________________ Phone:___________________________
Referring Physicians Signature, if available:_________________________________________

Please fax the following :
__ Referral Form __ Demographics __ Referral Form
__ H&P __ Medication List __ Updated Medication List
__ Picture ID __ Copy of Insurance

**Dialysis Center:**
Referred Center ___________________________ Phone: ______________ Fax: _______________
Nephrologists': _____________________________
Referred by (print and title) ___________________________ Initials: ______________
Referral Completed by: (Verbal Order – Nurse) ____________________________ Date:___________

**11989 Pellicano Drive • Suite D • El Paso, TX 79936**
**Phone:915.855.6508 • Fax: 915.855.6509**