VACCO AMBULATORY SURGERY CENTER
815 W Broad St, Suite 320
Columbus, OH 43222
614.221.0222 phone
614.221.9222 fax

Referral Form

Please Print All Information

Date: _____

Patient Name: _____

Patient Address: _____

Resident of Nursing Home: ☐ Yes ☐ No Facility Name: _____ Phone: _____

Patient Phone: _____ Patient DOB: _____

Patient SSN: _____ Mode of Transportation: _____

Primary Insurance: _____ Policy No.: _____

Secondary Insurance: _____ Policy No.: _____

Access Type: ☐ AV Graft ☐ AV Fistula ☐ No Existing Access ☐ Catheter

Location: ☐ Right ☐ Left ☐ Arm ☐ Thigh ☐ Chest

Date of Creation: _____ Surgeon: _____

Desired Procedure:

AVF / AVG: ☐ Declot ☐ Fistulogram / Graftogram

Catheter: ☐ Placement ☐ Exchange ☐ Repair ☐ Removal

Indication:

☐ Aneurysm	☐ Broken Catheter	☐ Clotted	☐ Difficult Cannulation
☐ Exposed Cuff	☐ Infection	☐ Infiltration	☐ Initiation of Dialysis
☐ High Venous Pressure	☐ Low Kt/V / URR	☐ Negative Arterial Pressure	
☐ No longer required	☐ Non-Maturing Fistula	☐ Pain	☐ Poor Blood Flow
☐ Prolonged Bleeding	☐ Recirculation	☐ Steal Syndrome	☐ Swollen Extremity
☐ Abnormal Surveillance	☐ Other: _____		

Clinical Information:

Dialysis Center Name: _____ Phone: _____

Last Dialysis Treatment: _____ Dry Weight: _____

Dialysis Days: ☐ Monday, Wednesday, Friday ☐ Tuesday, Thursday, Saturday

Allergies:

Contrast / Iodine / Shellfish	☐ Yes	☐ No	Reaction: _____
ChloraPrep / Chlorhexidine	☐ Yes	☐ No	Reaction: _____
Heparin	☐ Yes	☐ No	Reaction: _____
Lidocaine	☐ Yes	☐ No	Reaction: _____

Coumadin / Warfarin: ☐ Yes ☐ No PT / INR _____ Date: _____

Other Blood Thinner(s): _____

Primary Language: _____ Interpreter Required: ☐ Yes ☐ No

Competent to sign consent: ☐ Yes ☐ No If "No", POA _____ Phone: _____

Verbal Order – Nurse Signature: _____ Nephrologist: _____

Referring Physician's Signature, if available: _____

Please fax <u>completed</u> form along with Patient Demographic Sheet, Insurance Card(s), Medication List, H & P and Infectious Disease Status.