

# Referral Form

METRO VASCULAR CENTER

Dialysis Days: Mon,Wed,Fri / Tue,Thur,Sat

Today's date: \_\_/\_\_/\_\_

**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: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Last Dialysis Treatment: \_\_\_\_\_

<b>Access Type:</b>	<input type="checkbox"/> AV Graft / <input type="checkbox"/> AV Fistula	<input type="checkbox"/> Catheter	Date of Creation: _____
Location:	<input type="checkbox"/> Right / <input type="checkbox"/> Left	<input type="checkbox"/> Forearm / <input type="checkbox"/> Upper Arm	<input type="checkbox"/> Chest / <input type="checkbox"/> Thigh
Desired Procedure:	<input type="checkbox"/> Declot	<input type="checkbox"/> Fistulogram/Graftogram	<input type="checkbox"/> Venogram <input type="checkbox"/> Other _____
Indication:	<input type="checkbox"/> Clotted Access	<input type="checkbox"/> Steal Syndrome	<input type="checkbox"/> Non Maturing Fistula
	<input type="checkbox"/> Infiltration	<input type="checkbox"/> High Venous Pressure	<input type="checkbox"/> Transonic Monitoring
	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Difficult Cannulation	<input type="checkbox"/> Follow-up
	<input type="checkbox"/> Recirculation	<input type="checkbox"/> Swollen Extremity	<input type="checkbox"/> Aneurysm

<b>Catheter Procedure:</b>				
Site:	<input type="checkbox"/> Tunneled / <input type="checkbox"/> Non-Tunneled	<input type="checkbox"/> Right / <input type="checkbox"/> Left	<input type="checkbox"/> I J / <input type="checkbox"/> Groin	<input type="checkbox"/> Subclavian
Date of Insertion:	_____			
Desired Procedure:	<input type="checkbox"/> Insertion	<input type="checkbox"/> Catheter Change	<input type="checkbox"/> Removal	
Indication:	<input type="checkbox"/> Clotted Catheter	<input type="checkbox"/> Poor Function	<input type="checkbox"/> Infection	
	<input type="checkbox"/> Broken Catheter	<input type="checkbox"/> No Longer Required	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Exchange temporary catheter for permanent catheter			

<b>Clinical Information:</b>				
X-Ray Contrast Allergy? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Reaction? _____	
Diabetic? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last Hemoglobin Value: _____	Date: _____
Coumadin/Other Lytics? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any history of MRSA/VRE/Bedbugs .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competent to Sign Consent? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	..... If "No", by Whom? _____	Phone _____

<b>Transportation Needs:</b>	Does Patient have own transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Company _____	Phone	-----	_____
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Cane	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Stretcher
<input type="checkbox"/> Access Center Arranged Transport:	Company _____	Phone	-----	Initials _____
Post-procedure Destination:	<input type="checkbox"/> Home	<input type="checkbox"/> Dialysis Clinic	<input type="checkbox"/> Other _____	

<b>Dialysis Center:</b>	_____	Phone: _____ - _____ - _____	Fax	-----
Scheduled by: _____	Nephrologist: _____	Surgeon: _____		

<b>Insurance Info:</b>	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:

**Metro Vascular Center • 235 N. Broad Street, Suite 100 • Philadelphia, PA 19107**  
**Phone: 215-568-MVAC (6822) • Fax: 215-568-6833**

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