tri-county VASCULAR CARE
A Satellite Healthcare Partnership

Dialysis Access Referral Form

393 Blossom Hill Rd
Suite 365
San Jose, CA 95123
Phone: 408-225-2005
Fax: 408-225-2248

Today's date: ____-____-20____

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: ____-____-_____ Dialysis Days: Mon,Wed,Fri / Tue,Thur,Sat

Referring Nephrologist:_____

Access Type: ☐ Existing AV Graft ☐ Existing AV Fistula ☐ Existing Catheter ☐ New Access

Date of Creation: ____-____-_____ Surgeon:_____

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

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

☐ Patient referred to surgery clinic for placement of best access (AVG/AVF) ☐ Scheduled for percutaneous placement of PD catheter

Indication:

☐ Declining Qb _____	☐ Clotted Access	☐ Non Maturing Fistula	☐ Steal Syndrome
☐ Infiltration	☐ High Venous Pressure	☐ Transonic Monitoring	
☐ Prolonged Bleeding	☐ Difficult Cannulation	☐ Follow-up	
☐ Recirculation	☐ Swollen Extremity	☐ Aneurysm	

Catheter Procedure:

Type: ☐ Tunneled / ☐ Non-Tunneled ☐ HD Dialysis ☐ Peritoneal Dialysis

Site: ☐ Right / ☐ Left ☐ I J / ☐ Groin ☐ Subclavian ☐ Abdominal

Date of Insertion: ____-____-_____

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal

Indication: ☐ Clotted Catheter ☐ Poor Function ☐ Infection ☐ Exchange temporary catheter for permanent catheter

☐ Broken Catheter ☐ No Longer Required ☐ Other _____

Clinical Information:

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

Diabetic? ..... ☐ Yes ☐ No

Coumadin/Other Anticoagulants? ..... ☐ Yes ☐ No

If "Yes" to above, please specify: Eliquis(apixaban) Brilinta(ticagrelor) Pradaxa(dabigatran) Xarelto(rivaroxaban) Plavix(clopidogrel)

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

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

☐ Company _____ Phone _____-_____-_____

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher

Post-procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other _____

Dialysis Clinic: _____ Phone: _____-_____-_____ Fax: _____-_____-_____

Scheduled by:_____ Nephrologist:_____

Insurance 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 H+P, Demographics, copy of Insurance Cards, Picture ID, Medication List, Flow Sheets and most Recent Labs to: **Tri-County Vascular Care @ 408-225-2248**

For vascular use only. Appointment Date/Time: ____-____-20____ @ ____:____ Pickup Time: ____:____Confirmed By: