



4805 Montgomery Rd, Suite 140
 Cincinnati, OH 45212
 513.631.4555 phone
 513.631.5546 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 PD Catheter

Location: Right Left Arm Thigh Chest Abdomen

Date of Creation: _____ Surgeon: _____

Desired Procedure:

AVF / AVG: Declot Fistulogram / Graftogram Vessel Mapping

HD Catheter: Placement Exchange Repair Removal

PD Catheter: Replace Reposition 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: _____

ChloroPrep / 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 (and Signature, if available): _____

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