# Referral Form

7633 East Jefferson Ave, Suite 330
Detroit, Michigan 48214
Phone: 313-823-5338
Fax: 313-823-5950

Patient: ______________________________ Date: ______ / ______ / 20______

DOB: ______ / ______ / ______ Does patient have transportation? YES/NO

SSN: ______ / ______ / ______ Mobility: □ Ambulatory □ Wheelchair

Phone Number: ( ______ ) ______ - ______ □ Stretcher □ Cane/Walker

Nursing Home patient: YES / NO

Nursing Home: ______________________________

Dialysis days: MWF / TThSat Last Dialysis Treatment: ______/______/20______ Completed Treatment? YES/ NO

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## Access Type:

**□ AV Fistula / □ AV Graft**

**Location:** □ Left Forearm □ Right Forearm
□ Left Arm □ Right Arm
□ Left Thigh □ Right Thigh

***□ Catheter:*** □ Removal □ Insertion □Exchange

□ Left Chest / □ Right Chest
□ Left Thigh/ □ Right Thigh

**Indications:** □ Clotted Access □ Aneurysm
□ Prolonged bleeding □ Swelling/Infiltration
□ Decreased K t/v □ Pain
□ Non Maturing Fistula
□ Difficult Cannulation
□ Vessel Mapping

□ Poor Flow □ Clotted Catheter
□ Abnormal Surveillance
□ Infection
□ Broken Catheter
□ Exposed Cuff

**Other:** ______________________________

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Infection Control: □ HEP-C / HIV □ MRSA
□ VRE □ Bed Bugs
□ C-DIFF □ Head Lice

Pertinent Information:

*Coumadin/ Other Blood Thinners? ........ YES/ NO

*X-Ray Contrast Allergy? ........ YES/ NO

*Competent to sign owns consent? ........ YES / NO

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## Dialysis Center Information:

Dialysis Unit: ______________________ Nephrologist: ______________________

Vascular Surgeon: ______________________

**Referring Physician's Signature, if available:** ______________________

**Referral Completed by: (Verbal Order – Nurse)** ______________________

*TO EXPEDITE SCHEDULING -PLEASE FAX COMPLETED REFERRAL FORM; PATIENT DEMOGRAPHIC FORM; MOST CURRENT HOME MEDICATION LIST; MOST RECENT LAB VALUES AND LAST TREATMENT SHEET TO (313) 823 - 5950