REFERRAL FORM

Vascular Health and Wellness, LLC

Dialysis Days: Mon,Wed,Fri / Tue,Thur,Sat 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.: ______-______-________ D.O.B. ____________________ Last Dialysis Treatment: ____-____-______

Access Type: ☐ AV Graft / ☐ AV Fistula ☐ Catheter Date of Creation: ____-____-________

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

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

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

Catheter Procedure:

Site: ☐ Tunneled / ☐ Non-Tunneled ☐ Right / ☐ Left ☐ I J / ☐ Groin ☐ Subclavian

Date of Insertion: ____-____-________

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal

Indication:
☐ Clotted Catheter ☐ Poor Function ☐ Infection
☐ Broken Catheter ☐ No Longer Required ☐ Other ____________________
☐ Exchange temporary catheter for permanent catheter

Clinical Information:

X-Ray Contrast Allergy? …………… ☐ Yes ☐ No ☐ Reaction? ____________________

Diabetic? …………………………….. ☐ Yes ☐ No

Coumadin/Other Lytics? ……..….. ☐ Yes ☐ No

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

☐ Access Center Arranged Transport: Company__________________ Phone ______-______-______ Initials ______

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

Dialysis Center: ____________________ Phone: ______-______-________ Fax: ______-______-________

Scheduled by:____________________ Nephrologist:____________________ Surgeon:____________________

Insurance Info: 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) ____________________ **Date:**___________

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

Vascular Health and Wellness, LLC ●2300 Dawson Rd, Suite 100● Albany, GA 31707

Phone: 229-888-6466 ● Fax: 229-888-5464

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