



Referral Form

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.: ____-____-____

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 PD

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", 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) _____

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

**Advanced Access Medical Care | 1733 Eastchester Road, Suite 2 | Bronx, NY 10461
Phone: 718-409-2007 | Fax: 718-409-3374**

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