105 N. Hill Ave. Suite 200 • Pasadena, CA 91106 • Tel: 626.585.9300 • Fax: 626.585.9301

# Referral Form

Today's Date: __________ Desired Procedure Date: ___________ Person Completing Form: _________________

**Patient's Information**

Is patient from a nursing home? [ ] NO [ ] YES ….if "yes", use nursing home address and phone number below.

Legal Name: ________________________________________ Date of Birth: _____________ Gender: [ ] F [ ] M

Address: _______________________________City/Zip: ___________________ Phone Number: _________________

Emergency Contact: ______________________ Relationship: ______________ Phone Number: _________________

Referring Provider: ________________________ Phone Number: __________________ Fax: ___________________

**ALL OF THE FOLLOWING ARE REQUIRED TO BE FAXED TO FOOTHILL VASCULAR CENTER 626.585.9301 :**
**•Completed Referral •Signed Order •Demographic Sheet •Medication List**
**•Most Recent H&P •Most Recent Labs •Insurance Card(s)**

## AV ACCESS

**Dialysis Center**: ________________ **Phone**: _______________ **Fax**: ________________

**Nephrologist**: __________________ **Phone**: _______________

*Please Circle* **Dialysis Schedule**: M,W,F / T,Th,Sat / Other:________ **Last Dialysis Treatment**: ____________

**Type**: Fistula / Graft / Catheter **Date of Creation/Insertion**: __________ **Surgeon**: _________________

**Side**: Right / Left **Location**: Forearm / Upper Arm / Thigh / Chest / Intra-Jugular / Subclavian

**Desired Procedure**: **[ ]** Fistulogram/Angiogram **[ ]** Declot **[ ]** Ultrasound **[ ]** Removal (Catheter) **[ ]** Other:______

**Indication**: **[ ]** Aneurysm **[ ]** Clotted Access **[ ]** Difficult Cannulation **[ ]** Follow Up **[ ]** High VP **[ ]** Low AP
**[ ]** Infiltration **[ ]** Non-Maturing Fistula **[ ]** Prolonged Bleeding **[ ]** Poor Function **[ ]** Pain
**[ ]** Steal Syndrome **[ ]** Swollen Extremity **[ ]** No Longer Needed (Catheter) **[ ]** Other: ____________

## VASCULAR

**Desired Procedure**: **[ ]** Angiogram/Arteriogram – Location:__________ **[ ]** Angioplasty/Stent **[ ]** Atherectomy
**[ ]** Vein Ablation **[ ]** Other:______________

**Desired Study:** **[ ]** PVD Duplex **[ ]** PAD Duplex **[ ]** Vein Mapping **[ ]** Venous Reflux

**Indication**: **[ ]** Aneurysm **[ ]** Cramping of Extremity **[ ]** Cold Extremity **[ ]** Discoloration of Extremity
**[ ]** Follow Up **[ ]** Non-Healing Wound **[ ]** Numbness **[ ]** Pain
**[ ]** Recent Stroke/TIA **[ ]** Spider Veins **[ ]** Swollen Extremity **[ ]** Varicose Veins
**[ ]** AV Access Planning (Vein Mapping) **[ ]** Other: __________________

## CLINICAL INFORMATION

*Please Circle* **IV Dye, Contrast, or Shellfish Allergy?** No / Yes …. Reaction? ___________________________

**Diabetic?** No / Yes

**Blood Thinners/Anti-Coagulants?** No / Yes …. Coumadin / Plavix / Aspirin / Xarelto / Eliquis / Other

**VRE/MRSA Infection?** No / Yes …. Location? ___________________

**Competent to Sign Consent?** Yes / No …. By Whom? ____________________ Phone: __________________

**Ambulation Status:** Ambulatory / Cane / Walker / Wheelchair

Referring Provider's Signature: _____________________ Verbal Order RN Signature: ________________________
Date & Time VORB Received: ______________________