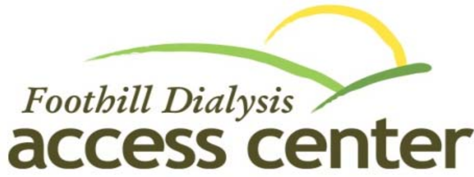
Referral Form



Today's date: ____-____-20____

Please fax completed form along with Doctor's Order, Medication List, Most Recent labs, Demographic Sheet, and Insurance Card(s)

Is patient a resident of a nursing home? ☐ No ☐ Yes

Patient Name: ____ D.O.B: ____________________

Contact No: ____________________________________ Last Dialysis: ____________________________

Patient Primary Language: ☐ English ☐ Spanish Other: __________________ S.S.N: ______________________

Dialysis Days: ☐ MWF ☐ TThS ☐ PD ☐ Nocturnal ☐ Home Hemo Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th

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

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

Desired Procedure: ☐ Declot ☐ Fistulogram/Angiogram ☐ Venogram ☐ Vein Mapping

Indication:
☐ Clotted Access ☐ Steal Syndrome ☐ Pain ☐ Immature Access ☐ Infiltration
☐ Aneurysm ☐ High Venous Pressure ☐ High Arterial Pressure ☐ Swollen Extremity
☐ Recirculation ☐ Difficult Cannulation ☐ Transonic/ Vasc-Alert Monitoring
☐ Prolonged Bleeding ☐ Decreased Blood Flow ☐ Other: ______________________________

Catheter Procedure:

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

Date of Insertion: ____-____-________

Desired Procedure: ☐ Insertion ☐ Exchange ☐ Removal

Indication:
☐ Initiation of Dialysis ☐ Clotted Catheter
☐ Poor Function ☐ Broken Catheter ☐ Infection *(please send cultures if available)* ****Date 1st Used:** ________________
☐ Fistula ☐ Graft
☐ Regained
☐ PD
☐ Exchange temporary catheter for permanent catheter

Clinical Information:

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

Competent to Sign Consent? ..…..… ☐ Yes ☐ No ….. If "No", by Whom? __________________ Phone: ______-______-________

Transportation Needs: Type of Transportation? ☐ Self ☐ Family ☐ Company____________________________

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher Phone ______-______-________

Dialysis Center: ____________________________ Scheduled by (Verbal Order – Nurse): ____________________________

Nephrologist: __________________________ Surgeon: ___________________________

Referring Physician's Signature, if available: ____

Foothill Dialysis Access Center ● 1317 West Foothill Blvd., Suite 110, Upland, CA 91786
Phone: 909-982-4040 ● Fax: 909-982-4024

For access center use only. Appointment Date/Time: ____ ☐ Faxed ☐ Text

Transportation arranged w/ ____ ☐ Faxed

Primary Ins: ______________________________ ☐ Approved Secondary Ins: ______________________________ ☐ Approved