

Referral Form

VASCULAR CENTER OF NEPHROLOGY
ASSOCIATES OF NORTHERN VIRGINIA

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: ____-____-____

New Access:

Bilateral Extremity Vessel Mapping for Arterial Venous Fistula Evaluation

Image Veins: with and without compression, document vein diameter and depth every 2 inches (or when significant change in size is seen) from wrist to shoulder — checking for vein continuity and ability to dialate with minimal compression
Image Arteries: Document vessel diameter and wave forms (checking for arterial stillness, calcifications, etc.)

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", 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.: _____

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

Vascular Center of Nephrology Associates of Northern Virginia • 13135 Lee Jackson Memorial Hwy • Suite 145 • Fairfax, VA 22033
Phone: 703-378-1360 • Fax: 703-378-7571

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