

PVG Cleveland East Vascular Care

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For Office Use Only

Initial Appointment Date: _____

Initial Appointment Time: _____

For Billing Office Use Only

ICD-10: _____

***Required Fields**

*Today's Date: _____ *Completed By: _____

*Patient Name: _____ *DOB: _____

*Address: _____ *Dialysis Schedule: MWF TTS

*Phone No.: _____ Or _____ *Shift: 1 2 3 4

*Dialysis Center: _____ Last Dialysis Treatment: _____

*Nephrologist: _____ *Dialysis Center Phone: _____ *Dialysis Center Fax: _____

*Skilled Nursing Facility (SNF): Yes No *SNF Name: _____ *SNF Phone: _____

*Hospice Patient: Yes No *Hospice Name: _____ *Hospice Phone: _____

*Access Type: Graft Fistula Catheter *Access Location: Right Chest Forearm Upper Arm
 Left Thigh Groin

Date of Creation: _____ Surgeon: _____

*Service Requested: Evaluate and Treat

AVF/AVG Indication:

- Clotted Access - Date Clotted: _____ Cold/Numbness/Pain Other: _____
- Recirculation Infiltration High Venous Pressure Non-Maturing Fistula
- Aneurysm Low BFR Difficult Cannulation Abnormal Functional Studies
- Low Kt/V Weak Thrill/Bruit Prolonged Bleeding Swollen Extremity Studies

Catheter Procedure Requested:

Date of Insertion: _____ Facility Where Placed: _____

- Type: Tunneled Non-tunneled Site: Right Left IJ Groin Subclavian
- Indication: Clotted Catheter Poor Function Broken Catheter No Longer Required Exchange temporary catheter for permanent catheter Other: _____

Desired Procedure: Insertion Catheter Exchange Removal

Clinical Information:

X-Ray Contrast Allergy? Yes No Reaction: _____

Diabetic? Yes No If yes, is the patient on insulin? Yes No

Anticoagulants? Yes No If yes, what type? _____

Competent to Sign Consent? Yes No If no, whom? _____

Is the patient ambulatory? Yes No Wheelchair? Yes No Stretcher? Yes No

Referring Physician or Nurse Signature: _____

Please fax form with demographics, insurance information, H&P and current medication list.

This referral expires one year from the date issued.