PREFERRED VASCULAR GROUP

NORTHEAST ATLANTA VASCULAR CARE
Improving the Flow of Life

Access Referral Form

PVG Northeast Atlanta Vascular Care
One Dunwoody Park South, Suite 130
Atlanta, GA 30338
P: 404.554.2080
F: 404.554.8021

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 ☐ Left ☐ Chest ☐ Thigh ☐ Forearm ☐ Groin ☐ Upper Arm

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.