

PVG Northwest Atlanta 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.