PREFERRED VASCULAR GROUP
MACON VASCULAR CARE
Improving the Flow of Life

# Access Referral Form

**PVG Macon Vascular Care**
**Kevin Sullivan, MD**
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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 ☐ 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.**