



Access Referral Form

PVG Northwest Atlanta Vascular Care
711 Canton Road NE, Ste 220, Marietta, GA 30060
P: 404.554.2196, F: 404.554.2415

*** Required Fields**

*Today's Date: _____	*Completed By: _____		
*Patient Name: _____	*DOB: _____		
*Address: _____	*Dialysis Schedule: <input type="checkbox"/> MWF <input type="checkbox"/> TTS		
*Phone No.: _____	*Shift: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
*Dialysis Center: _____	*Last Dialysis Treatment: _____		
*Nephrologist: _____	*Dialysis Phone: _____	*Dialysis Fax: _____	
*Skilled Nursing Facility (SNF): <input type="checkbox"/> Yes <input type="checkbox"/> No	*SNF Name: _____	*SNF Phone: _____	
*Hospice Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No	*Hospice Name: _____	*Hospice Phone: _____	
*Access Type: <input type="checkbox"/> Graft <input type="checkbox"/> Fistula <input type="checkbox"/> Catheter	*Access Location: <input type="checkbox"/> Right <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Upper Arm <input type="checkbox"/> Left <input type="checkbox"/> Thigh <input type="checkbox"/> Groin		
Date of Creation: _____	Surgeon: _____	*Service Requested: <input type="checkbox"/> Evaluate and Treat	

AVG/AVG Indication:

<input type="checkbox"/> Clotted Access - Date Clotted: _____	<input type="checkbox"/> Cold/Numbness/Paid _____	<input type="checkbox"/> Recirculation _____	<input type="checkbox"/> Infiltration _____
<input type="checkbox"/> High Venous Pressure _____	<input type="checkbox"/> Non-Maturing Fistula _____	<input type="checkbox"/> Aneurysm _____	<input type="checkbox"/> Low BFR _____
<input type="checkbox"/> Abnormal Functional Studies _____	<input type="checkbox"/> Low Kt/V _____	<input type="checkbox"/> Weak Thrill/Bruit _____	<input type="checkbox"/> Prolonged Bleeding _____
<input type="checkbox"/> High Arterial Pressure _____	<input type="checkbox"/> Other/Describe: _____		

Catheter Procedure Requested:

Date of Insertion: _____	Facility Where Placed: _____
Type: <input type="checkbox"/> Tunneled <input type="checkbox"/> Non-tunneled	Site: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> IJ <input type="checkbox"/> Groin <input type="checkbox"/> Subclavian
Indication: <input type="checkbox"/> Clotted <input type="checkbox"/> Poor Function <input type="checkbox"/> Broken Catheter <input type="checkbox"/> No Longer Required <input type="checkbox"/> Exchange temporary catheter for permanent catheter	
<input type="checkbox"/> Other/Describe: _____	
Desired Procedure: <input type="checkbox"/> Insertion <input type="checkbox"/> Catheter Exchange <input type="checkbox"/> Removal	

Clinical Information:

X-Ray Contrast Allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reaction/Describe: _____
Diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, is the patient on insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulants? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? _____
Competent to Sign Consent? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, then whom? _____
Is the patient ambulatory? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Stretcher? <input type="checkbox"/> Yes <input type="checkbox"/> No

FOLLOW UP CARE COORDINATION REQUEST

1. The Referring Physician Practice ("Practice") and Northwest Atlanta Vascular Care ("PVG") acknowledge that there is a significant need in the Atlanta community ("Community") for a comprehensive, high quality, accessible, cost-effective, and coordinated approach for the delivery of care to ESRD patients.
2. Practice and PVG desire to manage and coordinate care services for ESRD patients by offering coordinated care delivery and care coordination programs to assist with managing and improve care coordination and outcomes for ESRD patients which will specifically address reduction in potentially avoidable rehospitalization, reduction in unnecessary emergency department utilization and appropriate care strategies for ESRD patients that include vascular access services provided by PVG.
3. Practice requests that PVG provide: (a) ongoing assessment of the vascular access of the patient as determined to be medically necessary by Practice and/or PVG; (b) medically necessary and clinically appropriate medical interventions to address any vascular issues that materially affect a patient's ability to receive dialysis services; and (c) timely updates to Practice of all services provided by PVG to Practice's patients.

Signature: _____	Name: _____	Verbal or Fax Order received from: _____
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Please fax form with demographics, insurance information, H&P and current medication list.