



Access Referral Form

PVG Macon Vascular Care
889 Second Street, Macon, GA 31201
P: 478.254.9363, F: 478.254.9362

*** Required Fields**

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

*Patient Name: _____ *DOB: _____

*Address: _____ *Dialysis Schedule: MWF TTS

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

*Dialysis Center: _____ *Last Dialysis Treatment: _____

*Nephrologist: _____ *Dialysis Phone: _____ *Dialysis 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

AVG/AVG Indication:

Clotted Access - Date Clotted: _____ Cold/Numbness/Paid _____ 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 _____

High Arterial Pressure _____ Other/Describe: _____

Catheter Procedure Requested:

Date of Insertion: _____ Facility Where Placed: _____

Type: Tunneled Non-tunneled Site: Right Left IJ Groin Subclavian

Indication: Clotted Poor Function Broken Catheter No Longer Required Exchange temporary catheter for permanent catheter

Other/Describe: _____

Desired Procedure: Insertion Catheter Exchange Removal

Clinical Information:

X-Ray Contrast Allergy? Yes No Reaction/Describe: _____

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, then whom? _____

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

FOLLOW UP CARE COORDINATION REQUEST

1. The Referring Physician Practice ("Practice") and Macon Vascular Care ("PVG") acknowledge that there is a significant need in the Macon 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.