Access Referral Form

Please notate requested referral location. *Asterisk denotes required field.

PREFERRED VASCULAR GROUP

☐ **PVG Cleveland East Vascular Care**
23650 Commerce Park, Ste A
Cleveland, OH 44122
P: 216-273-8010 F: 216-378-9005

☐ **PVG Cleveland West Vascular Care**
23709 Center Ridge Road
Westlake, OH 44145
P: 216-516-8401 F: 440-550-4864

☐ **PVG Akron Vascular Care**
43 S Main Street
Munroe Falls, OH 44262
P: 234-349-8100 F: 234-312-0800

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

*Patient Name: _____ *DOB: _____

*Address: _____ *Dialysis Schedule: ☐ MWF ☐ TTS

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

*Dialysis Center: _____ *Last Dialysis: _____

*Nephrologist: _____ *Dialysis Phone: _____ *Dialysis Fax: _____

*Skilled Nursing Facility (SNF): ☐ Yes ☐ No *SNF Name: _____ *SNF Phone: _____

*Access Type: ☐ Fistula ☐ Graft ☐ Catheter *Access Location: ☐ Right ☐ Left ☐ Forearm ☐ Upper Arm ☐ Thigh ☐ Chest

AVF/AVG EVALUATION AND TREATMENT:

INDICATION:

☐ Difficult Cannulation ☐ Low Kt/V ☐ Prolonged Bleeding ☐ Infiltration

☐ High Venous Pressure ☐ High Arterial Pressure ☐ Aneurysm ☐ Low BFR ☐ Non-Maturing Fistula

☐ Abnormal Functional Studies ☐ Weak Thrill/Bruit ☐ Recirculation ☐ Cold/Numbness/Pain ☐ Swollen Extremity

☐ Clotted Access - Date Clotted: ☐ Other/Describe:

NEW DIALYSIS ACCESS CREATION

☐ Patient consultation with ultrasound vein mapping and clinic visit to evaluate for new **AV Fistula** for hemodialysis

☐ Patient consultation with clinic visit to evaluate for placement of a new **peritoneal dialysis catheter**

INDICATION: ☐ Patient is currently on hemodialysis ☐ Patient has CKD and the need for dialysis is anticipated

DIALYSIS CATHETER EVALUATION AND TREATMENT

PROCEDURE: ☐ Insertion ☐ Catheter Exchange ☐ Removal ☐ Clamp Repair

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

☐ Other/Describe:

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 the Preferred Vascular Group Vascular Center ("PVG") acknowledge that there is a significant need in the Northeast Ohio 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 coordinate care services for ESRD patients by offering coordinated care delivery and care coordination programs to assist with improving care coordination and outcomes for ESRD patients relating to vascular access which will specifically address reduction in potentially avoidable re-hospitalization, reduction in unnecessary emergency department utilization and appropriate care strategies for ESRD patients.
3. Practice requests that PVG provide: (i) medically necessary and clinically appropriate medical interventions to address any vascular issues that materially affect or reasonably could affect a patient's ability to receive dialysis services; (ii) ongoing monitoring of the vascular access of the patient on a quarterly basis or more frequently if determined to be medically necessary; and (iii) timely updates to Practice of all services provided by PVG to Practice's patients.

Signature:	Name:	Verbal or Fax Order received from:

Please fax form with demographics, insurance information, H&P and current medication list.