



105 N. Hill Ave. Suite 200 • Pasadena, CA 91106 • Tel: 626.585.9300 • Fax: 626.585.9301

Referral Form

Today's Date: _____ Desired Procedure Date: _____ Person Completing Form: _____

Patient's Information

Is patient from a nursing home? NO YESif "yes", use nursing home address and phone number below.

Legal Name: _____ Date of Birth: _____ Gender: F M

Address: _____ City/Zip: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Referring Provider: _____ Phone Number: _____ Fax: _____

ALL OF THE FOLLOWING ARE REQUIRED TO BE FAXED TO Foothill Vascular Center 626.585.9301 :

- Completed Referral •Signed Order •Demographic Sheet •Medication List
- Most Recent H&P •Most Recent Labs •Insurance Card(s)

AV ACCESS

Dialysis Center: _____ Phone: _____ Fax: _____

Nephrologist: _____ Phone: _____

Please Circle Dialysis Schedule: M,W,F / T,Th,Sat / Other: _____ Last Dialysis Treatment: _____

Type: Fistula / Graft / Catheter Date of Creation/Insertion: _____ Surgeon: _____

Side: Right / Left Location: Forearm / Upper Arm / Thigh / Chest / Intra-Jugular / Subclavian

Desired Procedure: Fistulogram/Angiogram Decлот Ultrasound Removal (Catheter) Other: _____

Indication: Aneurysm Clotted Access Difficult Cannulation Follow Up High VP Low AP

Infiltration Non-Maturing Fistula Prolonged Bleeding Poor Function Pain

Steal Syndrome Swollen Extremity No Longer Needed (Catheter) Other: _____

VASCULAR

Desired Procedure: Angiogram/Arteriogram – Location: _____ Angioplasty/Stent Atherectomy

Vein Ablation Other: _____

Desired Study: PVD Duplex PAD Duplex Vein Mapping Venous Reflux

Indication: Aneurysm Cramping of Extremity Cold Extremity Discoloration of Extremity

Follow Up Non-Healing Wound Numbness Pain

Recent Stroke/TIA Spider Veins Swollen Extremity Varicose Veins

AV Access Planning (Vein Mapping) Other: _____

CLINICAL INFORMATION

Please Circle IV Dye, Contrast, or Shellfish Allergy? No / Yes Reaction? _____

Diabetic? No / Yes

Blood Thinners/Anti-Coagulants? No / Yes Coumadin / Plavix / Aspirin / Xarelto / Eliquis / Other

VRE/MRSA Infection? No / Yes Location? _____

Competent to Sign Consent? Yes / No By Whom? _____ Phone: _____

Ambulation Status: Ambulatory / Cane / Walker / Wheelchair

Referring Provider's Signature: _____ Verbal Order RN Signature: _____

Date & Time VORB Received: _____