Foothill ARCADIA CALIFORNIA VASCULAR CENTER

Foothill Vascular Center
900 S. First Ave. Ste E
Arcadia, CA 91006
Phone: 626-585-9300 Fax: 626-585-9301
www.foothillvascular.com

REFERRAL FORM

☐ Routine ☐ Urgent Desired Procedure Date:_____

PATIENT INFORMATION

Is patient from a nursing home? ☐ No ☐ Yes. If yes, use nursing home address and phone number below.
Legal name:_____ Date of birth_____ Gender: ☐ Male ☐ Female
Address:_____ City/Zip Code:_____ 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
- Most Recent H&P and Labs
- Medication List
- Insurance Card(s)

AV ACCESS

Dialysis Center:_____ **Phone**:_____ **Fax**:_____
Nephrologist:_____ **Phone**:_____ **Fax**: _____
Please Circle **Dialysis Schedule**: M-W-F / T-TH-SAT **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 ☐ Declot ☐ 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 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. If yes, what reaction?_____
Diabetic? No / Yes
Blood Thinners/Anti-Coagulants? No / Yes. If yes, which of the following? Coumadin / Plavix / Aspirin / Xarelto / Eliquis / Other
VRE/MRSA Infection? No / Yes. If yes, what is the location?_____
Competent to Sign Consent? Yes / No
Ambulation Status: Ambulatory / Cane / Walker / Wheelchair

Referring Provider's Signature:_____Date_____
Verbal Order RN Signature:_____ Date & Time VORB Received:_____