



Referral Form

Dialysis Days: _____

Today's date: ____ - ____ -20____

PLEASE PRINT ALL INFORMATION

Is patient a resident of a nursing home? No ☐ Yes ☐ If "Yes", please use nursing home address and phone number (below).

Patient Name: _____

Patient Address: _____

Patient Phone No.: _____ Last Dialysis Treatment: ____ - ____ - ____

Access Type:	☐ AV Graft / ☐ AV Fistula	☐ Catheter	Date of Creation: ____ - ____ - ____
Location:	☐ Right / ☐ Left	☐ Forearm / ☐ Upper Arm	☐ Chest / ☐ Thigh
Desired Procedure:	☐ Declot	☐ Fistulogram/Graftogram	☐ Venogram ☐ Other _____
Indication:	☐ Clotted Access	☐ Steal Syndrome	☐ Non Maturing Fistula
	☐ Infiltration	☐ High Venous Pressure	☐ Transonic Monitoring
	☐ Prolonged Bleeding	☐ Difficult Cannulation	☐ Follow-up
	☐ Recirculation	☐ Swollen Extremity	☐ Aneurysm

Catheter Procedure:					
Site:	☐ Tunneled / ☐ Non-Tunneled	☐ Right / ☐ Left	☐ I / J / ☐ Groin	☐ Subclavian	☐ PD
Date of Insertion:	____ - ____ - ____				
Desired Procedure:	☐ Insertion	☐ Catheter Change	☐ Removal		
Indication:	☐ Clotted Catheter	☐ Poor Function	☐ Infection		
	☐ Broken Catheter	☐ No Longer Required	☐ Other _____		
	☐ Exchange temporary catheter for permanent catheter				

Clinical Information:	
X-Ray Contrast Allergy?	☐ Yes ☐ No ☐ Reaction? _____
Diabetic?	☐ Yes ☐ No
Coumadin/Other Lytics?	☐ Yes ☐ No
Competent to Sign Consent?	☐ Yes ☐ No If "No", Whom? _____ Phone: ____ - ____ - ____

Transportation Needs:	Does Patient have own transportation? ☐ Yes ☐ No
	☐ Company _____ Phone ____ - ____ - ____
☐ Ambulatory	☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher
☐ Access Center Arranged Transport:	Company _____ Phone ____ - ____ - ____ Initials _____
Post-procedure Destination:	☐ Home ☐ Dialysis Clinic ☐ Other _____

Dialysis Center:	_____ Phone: ____ - ____ - ____ Fax: ____ - ____ - ____
Scheduled by:	_____ Nephrologist: _____ Surgeon: _____

Insurance Info:	Patient D.O.B: ____ - ____ - ____ Patient S.S.N.: ____ - ____ - ____
Primary Insurance:	_____ Policy No.: _____
Secondary Insurance:	_____ Policy No.: _____

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

**Advanced Surgery Center | 1608 Lemoine Avenue, Ste 101 | Fort Lee, NJ 07024 |
Phone 201-585-9921 | Fax 551-800-3990**

For access center use only. Appointment Date/Time: ____ - ____ -20____ @ ____:____ Pickup Time: ____:____ Confirmed By: ____