REFERRAL FORM

formerly Midwest Vascular

9050 W. 81ST STREET • SUITE 700 • JUSTICE, IL 60458
TEL: 773.284.9247 • FAX: 773.284.9249

IF THIS IS A TIME SENSITIVE REQUEST, PLEASE CALL THE CENTER DIRECTLY.

TODAY'S DATE ____________ REQUESTED DATE ____________ ASAP ____________

PATIENTS NAME ____________

PATIENTS ADDRESS ____________

____

PATIENTS PHONE NUMBER ____________

DIALYSIS CENTER ____________

LAST DATE OF SUCCESSFUL DIALYSIS ____________

PATIENT REGULAR DIALYSIS DAYS

☐ M-W-F ☐ T-T-S ☐ M-F

☐ AM ☐ MID ☐ PM

PLEASE FAX THE FOLLOWING INFORMATION TO OUR OFFICE:

1. **DEMOGRAPHIC SHEET**
2. **MEDICATION LIST**
3. **INSURANCE CARD(S)**

REFERRING PHYSICIAN'S SIGNATURE ____________

ACCESS TYPE

☐ AVG ☐ AVF ☐ CATHETER

LOCATION: ☐ RT FOREARM ☐ LT FOREARM

☐ RT CHEST ☐ RT UPPER ARM ☐ LT UPPER ARM

☐ LT CHEST ☐ RT THIGH ☐ LT THIGH

INDICATION:

☐ INFECTION ☐ INFILTRATION ☐ REPAIR

☐ CLOTTED ☐ ANEURYSIM ☐ NO LONGER NEEDED

☐ DIFFICULT CANNULATION ☐ PROLONGED BLEEDING ☐ PAINFUL

☐ DECREASED ACCESS FLOW ☐ NON MATURING FISTULA ☐ SWELLING

☐ STEAL SYNDROME

OTHER ____________

CLINICAL INFORMATION

CONTRAST OR IV DYE ALLERGY? ☐ YES ________ Reaction ☐ NO ☐ PREP ORDERED

DIABETIC? ☐ YES ☐ NO

ANTICOAGULANTS? ☐ COUMADIN ☐ PLAVIX ☐ OTHER ____________

COMPETENT TO SIGN CONSENT? ☐ YES ☐ NO

IF NO -WHOM ____________

PHONE ____________

TRANSPORTATION

THE PATIENT MUST LEAVE THE CENTER WITH A RESPONSIBLE ADULT COMPANION. TRANSPORTATION IS THE RESPONSIBILITY OF THE PATIENT.

DIALYSIS CENTER

Fax: ____________ Nephrologist: ____________

Phone: ____________ Scheduled by: ____________ Surgeon: ____________

PRE-PROCEDURE INSTRUCTIONS FOR PATIENT

1. DO NOT EAT OR DRINK ANYTHING 6 HOURS BEFORE YOUR PROCEDURE
2. DO NOT DRIVE YOURSELF TO PROCEDURE. You must have a driver with you.
3. You may take your physician prescribed medications pre-procedure, with a small amount of water, ***EXCEPT*** **for the following blood thinners: Coumadin (Warfarin), Plavix, Aspirin and Lovenox**
4. Please bring a list of all current medications with you to your appointment.
5. Bring your photo ID and insurance cards with you to your appointment.
6. If you can not make your appointment please call 773.284.9248 to reschedule. We are available 24hrs a day, 7 days a week.
7. **PLEASE BE PREPARED TO STAY AT THE FACILITY FOR AT LEAST 3 - 4 HRS.**

PATIENT NAME____________________________

Has an appointment on: ________________

Date: ______________ Time:______________

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