Referral Form

1445 Georgia Ave., Suite 1
Macon, GA 31201
478-250-1328 office
478-238-4187 fax

Please fax Face Sheet, Doctor Script, Copies of Insurance, Medication Lists, Labs, & most recent H&P with Referral Form.

Today's Date: _____ Requested Procedure Date: _____
Patient's Name: _____
Primary Insurance (Please fax copy of card):_____
Secondary Insuarnce (Please fax copy of card):_____
If nursing home, please indicate and use that address and phone number.

Procedure

Location: ☐ Right/ ☐ Left ☐ Forearm ☐ Upper Arm ☐ Chest ☐ Thigh

Desired Procedure: ☐ Port Insertion ☐ Port Removal ☐ Port Revision ☐ Picc Line ☐ Fistulagram/Graftogram
☐ Permacath Insertion ☐ Permacath Removal
☐ Venogram ☐ Arteriogram ☐ Aortogram w/runoff ☐ Other _____

Indication: ☐ Clotted Catheter ☐ Poor Function ☐ Non Maturing Fistula
☐ High Venous Pressure ☐ Infiltration ☐ Transonic Monitoring
☐ Prolonged bleeding ☐ Difficult Cannulation ☐ Steal Syndrome
☐ Recirculation ☐ Swollen Extremity ☐ Aneurysm

Catheter

Site: ☐ Tunneled / ☐ Non tunneled ☐ Right / ☐ Left ☐ Chest/ ☐ Groin

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal ☐ Other

Indication

☐ Clotted Catheter ☐ Poor Function ☐ Painful Catheter
☐ Broken Catheter ☐ No Longer Required Infection
☐ Exchange temporary catheter for permanent catheter ☐ Other

Clinical Information

Xray Contrast Allergy? ☐ Yes ☐ No Reaction?_____
Allergies? _____ ☐ Yes ☐ No Reaction?_____
Diabetic? ☐ Yes ☐ No
Any Anticoagulants? ☐ Yes ☐ No ☐ Coumadin ☐ Plavix ☐ ASA ☐ Other _____

Dialysis Center

Referred By: _____ Phone: _____ Fax#:_____
Nephrologist: _____ Surgeon: _____
Appointment Date/Time: _____ Confirmed By: _____
Emergency Contact _____ Relationship _____ Contact # _____
Competent to Sign Consent? ☐ Yes ☐ No If no, Whom? _____ Phone #_____
Stretcher: ☐ Yes ☐ No
Transportation (Contact/Phone): _____