tri-county VASCULAR CARE

Referral Form

PLEASE PRINT ALL INFORMATION

393 Blossom Hill Rd. Suite
365 San Jose, CA 95123
Phone 408.225.2005
Fax 408. 225.2248

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

Name: ____________________ Dialysis Schedule : MWF/ TTS (please circle one)

Address: ____________________Phone : _____-_____-__ Last Dialysis Treatment: ____________

Access Dysfunction: ☐ Existing AV Graft ☐ Existing AV Fistula ☐ New Access Date of Creation ___/ ____/ _____

Surgeon: ____________________

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

Desired Procedure: ☐ Declot ☐ Fistulogram / Graftogram ☐ Venogram ☐ Other ____________________

REQUIRED ☐ Clotted Access ☐ Steal Syndrome ☐ Non Maturing Fistula ☐ Infiltration ☐ High Venous Pressure

INDICATION ☐ Unable to maintain prescribed blood flow ☐ Prolonged Bleeding ☐ Difficult Cannulation

☐ Change in Aneurysm/ Pseudoaneurysm ☐ Abnormal Transonics (add indication) other: _________

Evaluation: ☐ Placement of best access ☐ Placement of Peritoneal Catheter ☐ Peripheral Arterial Disease

☐ Change in Modality ☐ Pain in legs when walking ☐ Non healing foot /leg wound ☐ Leg Pain at Rest

Catheter Dysfunction ☐ Tunneled / ☐ Non-Tunneled ☐ HD – Dialysis ☐ Peritoneal Dialysis

Location: ☐ Right / ☐ Left ☐ I J / ☐ Groin ☐ Subclavian ☐ Abdominal Date of Insertion: ___/ ____/ _____

Desired Procedure: ☐ New Insertion ☐ Catheter Exchange ☐ Removal

REQUIRED: ☐ Clotted Catheter ☐ Poor Function ☐ Infection

INDICATION ☐ 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 Anticoagulants- Eliquis, Brillenta, Pradaxa, Plavix, Xarelto ☐ 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

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.: ____________________

Referring Physician's Signature, if available:____________________

Referral Completed by: (Verbal Order – Nurse) ____________________

Please Fax completed form, along with H & P, Demographics, copy of Insurance Cards, Picture ID, & Medication List.
Flow sheets & recent labs to: Tri Country Vascular Care @ 408- 225- 2248

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