12134 Victory Blvd.
North Hollywood, CA 91606

NORTH HOLLYWOOD CARDIO-VASCULAR CENTER

Ph: 888-526-4848
Fax: 818-927-2088

ESRD PATIENT REFERRAL

Please fax completed form along with Patient Demographic sheet, Insurance card(s) and medication list – Thank You!

Today's date: _____ Requested procedure date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

Last Dialysis Treatment: _____

If nursing home, please indicate name, address and phone number of facility below:

Name: _____ Address: _____ Phone: _____

Primary Insurance: _____ Policy No.: _____ SSN: _____

Secondary Insurance: _____ Policy No.: _____ SSN: _____

ACCESS TYPE:

☐ AV Graft ☐ AV Fistula ☐ Catheter Date of Creation: _____-_____-_____

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

GRAFT / FISTULA PROCEDURE:

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

INDICATION:

☐ Clotted Access ☐ Steal Syndrome ☐ Non Maturing Fistula ☐ Pain
☐ Infiltration ☐ High Venous Pressures ☐ Transonic Monitoring ☐ Other_____
☐ Prolonged Bleeding ☐ Difficult Cannulation ☐ Follow-up
☐ Recirculation ☐ Swollen Extremity ☐ Aneurysm

CATHETER PROCEDURE:

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

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal

INDICATION:

☐ Clotted Catheter ☐ Poor Function ☐ Infection
☐ Broken Catheter ☐ No Longer Required ☐ Other _____
☐ Exchange temporary catheter to permanent catheter

CLINICAL INFORMATION:

X-Ray Contrast Allergy? .....☐ Yes ☐ No ☐ Reaction ? _____
Diabetic?.....☐ Yes ☐ No
Coumadin/Plavix/Other Lytic?.....☐ Yes ☐ No
Competent to Sign Consent ?.....☐ Yes ☐ No….. If No, Whom ? _____ Phone: _____

TRANSPORTATION NEEDS:

Does Patient have own transportation? Self/Relative? _____

☐ Company _____ Phone: _____

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher

☐ PV Arranged Transport: Company _____ Phone: _____ Initials: _____

Post-procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other: _____

DIALYSIS CENTER:

Name: _____ Phone: _____ Fax: _____

Referred by: _____; Nephrologist: _____; Surgeon: _____

Phone: _____ Fax #: _____

Physician Signature: _____ Date: _____