Dallas Vascular Center

1222 N. Bishop Ave., Ste. 500, Dallas, TX 75208 PH: 214-943-1687 FAX: 214-943-9373

****This form is an official request for treatment and serves as a Physician's order**

Dialysis Patient Referral/Appointment Request

Patient Name:			DOB:		
Patient Current Phone:					
Current Dialysis Schedule: (Please Circle One)	MWF	TTS	Shift: 1 2 3	Nocturnal	Home Hemo
Dialysis Center:			Phone:		
Referring Physician:					
Nurse Name:			Phone:		
Nurse Signature:			Date:		

NOTE: For the following, please check one or more as appropriate:

Procedure Requested

Fistula/Graft Procedures
[ ] Angiogram/Fistulogram
[ ] Declot/Thrombectomy

UltraSound Procedures
[ ] Vessel Mapping
[ ] Ultrasound/Doppler

Indications
[ ] Increased Arterial Pressure
[ ] Increased Venous Pressure
[ ] Pulsatile Graft/Fistula
[ ] Prolonged Bleeding
[ ] Decreased URR or Kt/V
  [ ] URR <65%
  [ ] Kt/V <1-2
[ ] Low Access Flow
[ ] Non-Maturing Access
[ ] Access Maturity Evaluation

Indications (cont'd)
[ ] Clotted Access
[ ] Difficult Cannulation
[ ] Possible Stenosis
[ ] Weak Extremity Pulse
[ ] Pain
[ ] Swelling
[ ] Infection
[ ] Pulling Clots
[ ] Aneurysm

HD Catheter Procedures
[ ] Catheter Placement
[ ] Catheter Exchange
[ ] Catheter Removal

[ ] Non-Functioning Catheter
[ ] Catheter Exposed/Damaged
[ ] Infection

Access Information: Please Circle All Appropriate Information:

Type of Access:	A/V Fistula	Graft	Catheter		
Location:	Upper Arm	Forearm	IJ	Subclavian/Chest	Femoral
Side:	**LEFT**	**RIGHT**			

IMPORTANT REMINDERS

- Please FAX a copy of the following to DVC along with this referral form:
  - Face Sheet
  - Medication List
  - Most Recent H & P
  - Most Recent Insurance Information

Please give the patient his/her copy of the **PATIENT APPOINTMENT INSTRUCTIONS** provided by DVC.