REFERRAL FORM

Merrillville Vascular Center

100 W. 86th Avenue • Merrillville, IN 46410
Phone: 219-472-1350 • Fax: 219-769-1350

IF THIS IS A TIME SENSITIVE REQUEST, PLEASE CALL THE CENTER DIRECTLY.
****INCOMPLETE FORMS AND/OR MISSING INFORMATION MAY DELAY THE SCHEDULING PROCESS ****

TODAY'S DATE ____________________ REQUESTED DATE ________________

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)**

ACCESS TYPE

☐ AVG ☐ AVF ☐ CATHETER

☐ RT FOREARM ☐ LT FOREARM ☐ RT CHEST

☐ RT UPPER ARM ☐ LT UPPER ARM ☐ LT CHEST

☐ RT THIGH ☐ LT THIGH

INDICATION:

☐ INFILTRATION ☐ REPAIR

☐ INFECTION ☐ ANEURYSM ☐ NO LONGER NEEDED

☐ CLOTTED ☐ PROLONGED BLEEDING ☐ PAINFUL

☐ DIFFICULT CANNULATION ☐ NON MATURING FISTULA ☐ SWELLING

☐ DECREASED ACCESS FLOW ☐ STEAL SYNDROME ☐ OFFICE VISIT

OTHER ____

CLINICAL INFORMATION

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

DIABETIC? ☐ YES ☐ NO

ANTICOAGULANTS? ☐ COUMADIN ☐ PLAVIX ☐ OTHER ____________

COMPETENT TO SIGN CONSENT? ☐ YES ☐ NO IF NO -WHOM ____________

PHONE ____________

LAST TWO ACCESS FLOW READINGS (REQUIRED)

____________ READING ____________ DATE ____________ READING ____________ DATE

TRANSPORTATION

Can patient provide own transportation to and from facility?
__ Yes __ Needs transportation

DIALYSIS CENTER

Fax:____________ Nephrologist:____________

Phone:____________ Scheduled by:____________ Surgeon:____________