REFERRAL FORM

DuPage Access Center

7425 Janes Ave • Suite 101 • Woodridge, IL 60517-2319
Phone: 630-929-5700 • Fax: 630-241-1197

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:**_____

FULL NAME : _____

DOB : _____

ADDRESS : _____

CITY, STATE ZIP : _____

PHONE : _____

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:

DEMOGRAPHIC SHEET MEDICATION LIST
INSURANCE CARD(S)

ACCESS TYPE: Location - RT / LT

☐ AVG ☐ PAVF ☐ AVF ☐ No Access ☐ Vein Mapping (specify surgeon) _____

☐ Catheter Location: ☐ Chest RT or LT ☐ Groin RT or LT

INDICATION:

☐ **Abnormal Bruit/Thrill** ☐ **Aneurysm** ☐ **Broken** ☐ **Clotted** ☐ **Decreased Access Flow** ☐ **Difficult Cannulation**

☐ **Exchange** ☐ **High Venous Pressure** ☐ **Infection** ☐ **Infiltration** ☐ **New Placement** ☐ **No Longer Needed**

☐ **Non Maturing Fistula** ☐ **Office Visit** ☐ **Painful** ☐ **Poor Arterial Pressure** ☐ **Poor Function** ☐ **Poor Kt/v Clearance**

☐ **Prolonged Bleeding** ☐ **Recirculation** ☐ **Repair** ☐ **Steal Syndrome** ☐ **Swelling** ☐ **Other:** _____

CLINICAL INFORMATION

Contrast or IV Dye allergy?

☐ Yes Reaction_____

☐ No ☐ Prep Ordered

Diabetic?

☐ Yes ☐ No

Anticoagulants:

☐ Coumadin ☐ Plavix ☐ Eliquis

☐ Brilinta ☐ N/A ☐ Other: _____

Competent to sign consent?

☐ Yes ☐ 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

Post Procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other: _____

DIALYSIS CENTER

Referring Physician:_____ Nephrologist:_____ Surgeon:_____

Phone:_____ Fax:_____ Scheduled By:_____