REFERRAL FORM

Willow Springs Surgery Center

9050 W. 81st Street, Justice, IL 60458
Phone: 773-284-9247 • Fax: 773-284-9249

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 ______________________________

INSURANCE TYPE ______________________________

POLICY NUMBER ______________________________

PHONE ______________________________

DIALYSIS CENTER ______________________________

CKD PATIENT? ☐ YES ☐ NO

CKCC PATIENT? ☐ YES ☐ NO

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)**

APPOINTMENT TYPE

CONSULT /OFFICE VISIT ________

SURGICAL ACCESS CREATION ________

REVISION OF DIALYSIS ACCESS ________

PERITONEAL CATHETER ________

☐ Insertion ☐ Revision ☐ Removal

LOCATION Left / Right

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

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

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

Pacemaker?

☐ Yes ☐ No ***LOCATION***: Left / Right

Whom: ______________ Phone: ____________

TRANSPORTATION

Can patient provide own transportation to and from facility?

☐ Yes ☐ Needs transportation

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

Referring Physician: ______________________ Nephrologist: ______________________

Phone: ______________________ Scheduled By: ______________________

V1 8.24.22