NANI VASCULAR

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 _____

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 _____ Reaction ☐ NO

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:_____