SAVANNAH VASCULAR INSTITUTE - The Access Center
REQUEST FOR CONSULTATION
Main Waters Ave office: (912) 629-7800 / Fax: (912) 356-1221 / Scheduler (912) 629-7874

Dialysis Consult

Patient's Name:_____ DOB:_____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____

Email: SSN:

Person other than patient to arrange appointment (Name): _____

Phone: Relationship to patient:

☐ Medicare # _____ ☐ Self Pay / Pt/Ref Dr notified of payment due

Insurance Plan: _____ ID#: _____

Address: _____ Prior Approval Needed: _____ Yes _____ No

_____ Authorization #: _____

Out of Network: Physician notified: Patient Notified:

Nephrologists: _____ Office Phone #: _____

Address: _____ NPI #: _____

Dialysis Center: _____ Center's phone #: _____

Contact Person:_____ Center's fax #: _____

Physician Requested: **Avino** **Wixon** **Cohn** **Walls** **Ellison** **Mondy** **Brown** **Moon**
Horesh **Nelson** **O'Kelley** **ANY/ 1st Available** **(Please Circle)**

Reason for Consultation:

Patient should be seen: Emergent 24 Hours 72 Hours Within Week Next Available
(please circle one)

******WE MUST HAVE THIS INFORMATION IN ORDER TO MAKE AN APPOINTMENT. WE WILL NOT MAKE ONE WITHOUT IT********

_____ Last Two Office Notes
_____ List of Current Medications
_____ Any Vascular Test Pertinent to Consult
_____ Insurance Cards

Person completing this form: Date/Time Received:

Notes: _____

_____

Appointment Scheduled: Date _____ Time: _____ Physician: _____

Referring Dr. notified _____ Info faxed to Dr's office / Dialysis Center _____ Mailed to patient _____