SAVANNAH VASCULAR INSTITUTE
The Vein & Artery Experts

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DIALYSIS PATIENT PROCEDURE SCHEDULING REFERRAL FORM ****Please Include Current Medications List**

Patient Name: _____ DOB: _____ Date of call:_____

Physician: AVINO BROWN COHN ELLISON HORESH MONDY MOON NELSON WALLS

Dialysis Center: _____ Phone Number: _____

Contact Person:_____ Fax Number: _____

Which of the following access does the patient have? **FISTULA** **GRAFT** **CATHETER**

Where is the access located? **LEFT** **RIGHT** **UPPER-ARM** **FOREARM** **THIGH**

What is wrong with the access/reason for visit? _____
_____

Does the Access have an Aneurysmal Area (*Shiny Spot*)? Yes_____ No_____

Last full run date: _____ lbs. over dry weight: _____ SOB: Yes _____ No _____

DOES THE PATIENT NEED DIALYSIS TODAY? YES _____ No_____ Patient Chair Time:_____

Days: **M W F** **T TH S** **M W TH F** Patient's Neph: _____ Dialysis start date: _____

ALLERGIES/NKA:_____ Is the patient on **Coumadin**? **YES NO**

If CONTRAST / DYE ALLERGY – PREP CALLED INTO _____BY _____ON_____

How does the patient transport? PATIENT DRIVES FAMILY TRANSPORT SERVICE: _____

Does the patient have insurance? **YES NO** Insurance:_____

FOR SVI OFFICE USE ONLY:

Procedure: _____ Date: _____

Procedure time: _____ Arrival time: _____

OFFICE TOWER SPOKE W/ _____ IN HOSP SCH AT: _____

SPOKE W/ _____ IN ANGIO AT _____

SPOKE W/ _____ IN EPU _____

SPOKE W/ _____ AT _____ Dialysis Center

INFO FAXED TO: _____CENT SCH _____ ANGIO _____MMC DIALYSIS CENTER

SPOKE W/ _____WITH THE DIALYSIS CENTER AT MMC

REMINDER MAILED TO PATIENT ON: _____ TO DIALYSIS CENTER ON: _____