

12134 Victory Blvd.  
North Hollywood, CA 91606



**NORTH HOLLYWOOD  
CARDIO-VASCULAR  
CENTER**

**Ph: 888-526-4848  
Fax: 818-927-2088**

## ESRD PATIENT REFERRAL

Please fax completed form along with Patient Demographic sheet, Insurance card(s) and medication list – Thank You!

Today's date: \_\_\_\_\_ Requested procedure date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Last Dialysis Treatment: \_\_\_\_\_

If nursing home, please indicate name, address and phone number of facility below:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy No.: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy No.: \_\_\_\_\_ SSN: \_\_\_\_\_

### ACCESS TYPE:

Location:  AV Graft  AV Fistula  Catheter  Forearm  Upper Arm  Chest  Thigh  
 Right  Left  Forearm  Upper Arm  Chest  Thigh  
Date of Creation: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### GRAFT / FISTULA PROCEDURE:

Desired Procedure:  Declot  Fistulogram/Graftogram  Venogram  Other \_\_\_\_\_

INDICATION:  Clotted Access  Steal Syndrome  Non Maturing Fistula  Pain  
 Infiltration  High Venous Pressures  Transonic Monitoring  Other \_\_\_\_\_  
 Prolonged Bleeding  Difficult Cannulation  Follow-up  
 Recirculation  Swollen Extremity  Aneurysm

### CATHETER PROCEDURE:

Site:  Tunneled  Non Tunneled  
 Right  Left  Chest /  Groin

Desired Procedure:  Insertion  Catheter Change  Removal

INDICATION:  Clotted Catheter  Poor Function  Infection  
 Broken Catheter  No Longer Required  Other \_\_\_\_\_  
 Exchange temporary catheter to permanent catheter

### CLINICAL INFORMATION:

X-Ray Contrast Allergy? .....  Yes  No  Reaction ? \_\_\_\_\_  
Diabetic?.....  Yes  No  
Coumadin/Plavix/Other Lytic?.....  Yes  No  
Competent to Sign Consent ?.....  Yes  No..... If No, Whom ? \_\_\_\_\_ Phone: \_\_\_\_\_

### TRANSPORTATION NEEDS:

Does Patient have own transportation? Self/Relative? \_\_\_\_\_  
 Company \_\_\_\_\_ Phone: \_\_\_\_\_  
 Ambulatory  Cane  Walker  Wheelchair  Stretcher  
 PV Arranged Transport: Company \_\_\_\_\_ Phone: \_\_\_\_\_ Initials: \_\_\_\_\_  
Post-procedure Destination:  Home  Dialysis Clinic  Other: \_\_\_\_\_

### DIALYSIS CENTER:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Referred by: \_\_\_\_\_; Nephrologist: \_\_\_\_\_; Surgeon: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_