EMIS | Elite Minimally Invasive Specialists

DIALYSIS REFERRAL FORM

Patient Name: _____ Today's Date: _____

Patient Phone: _____ Patient DOB: _____

Primary Insurance: _____ ID # _____

Referring Physician: _____ Contact Name: _____

Dialysis Clinic : _____ Phone # : _____

1. AV FISTULA/GRAFT

☐ EVALUATION

2. HEMODIALYSIS CATHETER:

☐ PLACEMENT ☐ EXCHANGE ☐ REMOVAL

3. PERITONEAL CATHETER:

☐ EVALUATION ☐ PLACEMENT ☐ EXCHANGE ☐ REMOVAL

4. PERCUTANEOUS AV FISTULA CREATION

☐ EVALUATION

REASON FOR REFERRAL

☐ CLOTTED ACCESS ☐ ANEURYSM ☐ INFILTRATION ☐ NON-MATURING FISTULA
☐ STEAL SYNDROME ☐ ELEVATED VENOUS PRESSURE ☐ RECIRCULATION
☐ DIFFICULT CANNULATION ☐ PROLONGED BLEEDING ☐ SWOLLEN EXTREMITY

☐ ABNORMAL PAIN ☐ INFECTION ☐ NOT FUNCTIONING ☐ NO LONGER NEEDED

OTHER: _____

ACCESS SITE LOCATION:

☐ ARM ☐ LEG ☐ CHEST ☐ FEMORAL ☐ ABDOMEN
☐ LEFT ☐ RIGHT

ADDITIONAL COMMENTS:

_____

Thank You for The Opportunity to Participate in Your Patient's Health Care

PLEASE ATTACH PATIENT:
DEMOGRAPHIC SHEET, RECENT H&P, TREATMENT FLOWSHEETS, MOST RECENT LABS, MEDICATION LIST, INSURANCE CARDS

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