vascular center

Minimally Invasive Medicine Specialists

GENERAL REFERRAL FORM

Fax to: (909) 391-9101

Please include: Face Sheet, Medication List, Doctor Script, Copy of Insurance Card, Most Recent H&P and Labs

Today's Date _____

Requested Procedure Date _____

***PATIENT'S INFORMATION** (If nursing home, please indicate here ☐ and use that address and phone)*

Name: _____ **DOB** _____

Address _____

Phone Number _____ **Last Dialysis Treatment** _____

Insurance _____ **Diagnosis** _____

Dialysis Center _____ **Ph** _____ **Fax** _____

Nephrologist _____ **Person Giving Info** _____

PROCEDURE ☐ AV Graft ☐ AV Fistula - Date Created _____

LOCATION ☐ Right ☐ Left ☐ Forearm ☐ Upper arm ☐ Chest ☐ Thigh

DESIRED PROCEDURE ☐ Angioplasty ☐ Aortorgram w/run off ☐ PICC Line ☐ Fistulagram ☐ Thrombectomy ☐ Arteriorgram ☐ Venogram ☐ Other

INDICATION ☐ Clotted Access ☐ High Venous Pressures ☐ Steal Syndrome ☐ Swollen Extremity ☐ Non Maturing ☐ Prolonged Bleeding ☐ Infiltration ☐ Difficult Cannulation

CATHETER ☐ Tunneled ☐ Non-tunneled ☐ Insertion ☐ Exchange ☐ Removal

CLINICAL INFORMATION Contrast Allergy? Yes ☐ No

If Yes, Reaction? _____

Diabetic?	Insulin?	Coumadin?	Plavix?	ASA?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Yes No	Yes No

ABLE TO CONSENT? ☐ Yes ☐ No

Emergency Contact _____

Transportation: _____

Physicians Signature _____ Date _____

1520 N Mountain Ave, Bld E
Suite 205, Ontario, CA, 91762

(909) 235-7490 (909) 391-9101
www.ontariointerventional.com