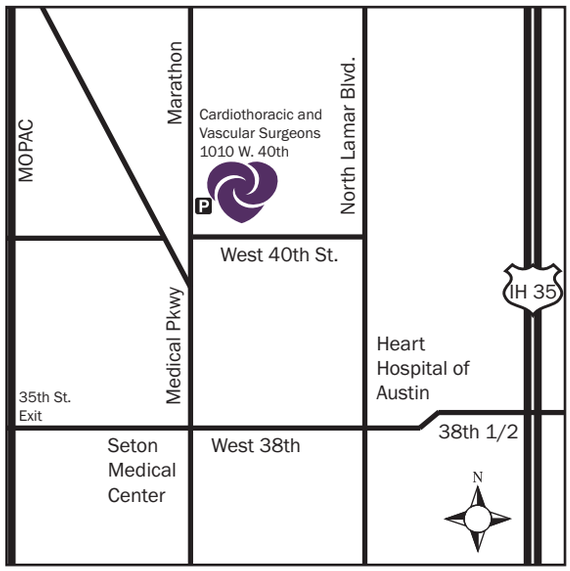
Cardiothoracic and Vascular Surgeons

1010 West 40th Street
Austin, TX 78756
www.ctvstexas.com
ph 512.459.8753
fax 512.459.0586

ESRD/Dialysis Referral Form

If this is an urgent matter, please call our office



Patient Name: _____

Patient Address:_____

City:_____ State:_____ Zip:_____

Phone (_____) _____ Email Address:_____

SSN: _____ - _____ - _____ Date of Birth:_____

Nephrologist OR Referring Physician:

_____

Is patient in a nursing home? ☐ Yes ☐ No

Nursing Home Name: _____

Phone (_____) _____

Referral to see:

☐ First Available OR Please check one of the boxes below

☐ Phillip J. Church, MD	☐ Jeffrey S. Jobe, MD	☐ Scott A. Seidel, MD	☐ David A. Nation, MD
☐ Mark T. Stewart, MD	☐ Stephen M. Settle, MD	☐ Jeffrey M. Apple, MD	
☐ John K. Politz, MD	☐ Joe K. Wells, MD	☐ Mazin I. Foteh, MD	

Dialysis Information:

Is patient on dialysis? ☐ Yes ☐ No

If yes, method of dialysis: ☐ Fistula/Graft ☐ PD Cath ☐ Perm Cath

If yes, first date of dialysis:_____ _____

Dialysis Unit:_____ Phone (_____) _____ Contact Name:_____

Dialysis Days: ☐ Mon/Wed/Fri ☐ Tues/Thurs/Sat ☐ Other:_____

Reason for referral:

☐ Fistula/Graft: Creation OR Problem:_____

☐ PD Cath: Placement OR Problem:_____

☐ Permcath: Placement OR Problem:_____

☐ Other_____

Please send with all referrals:

- **Demographics/Insurance**
- **Recent Progress/Office Note**
- **History & Physical**
- **Medication List**

Without the above information, scheduling the patient will be delayed.

Preferred Hospital: _____

When Completed, Please Fax to 512.459.0586