Cardiothoracic and Vascular Surgeons

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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 (_____) _____

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