Cardiothoracic and Vascular Surgeons

ESRD/Dialysis Referral Form

If this is an urgent matter, please call our office

1010 West 40th Street
Austin, TX 78756
ph 512.459.8753
fax 866.591.1084

3201 South Austin Ave.
Suite 235
Georgetown, TX 78626
ph 512.501.4293
toll free 888.400.6547
fax 866.591.1084

1180 Seton Parkway
Suite 250
Kyle, Texas 78640
ph 512.651.8420
toll free 866.746.1378
fax 866.591.1084

www.ctvstexas.com

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
☐ John K. Politz, MD
☐ Jeffrey S. Jobe, MD
☐ Stephen M. Settle, MD
☐ Joe K. Wells, MD
☐ Scott A. Seidel, MD
☐ Jeffrey M. Apple, MD
☐ Mazin I. Foteh, MD
☐ Bradley A. Boone, MD
☐ David A. Nation, MD
☐ Ryan S. Turley, MD
☐ Taylor A. Smith, MD
☐ Nicolas Zea, 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 866.591.1084