



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 (_____) _____

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

930 Kohlers Crossing
Ste. 650
Kyle, TX 78640
ph 512.651.8420
toll free 866.746.1378
fax 866.591.1084

www.ctvstexas.com

Referral to see:

First Available OR Please check one of the boxes below

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Phillip J. Church, MD | <input type="checkbox"/> Joe K. Wells, MD | <input type="checkbox"/> Bradley A. Boone, MD | <input type="checkbox"/> Taylor A. Smith, MD |
| <input type="checkbox"/> John K. Politz, MD | <input type="checkbox"/> Scott A. Seidel, MD | <input type="checkbox"/> David A. Nation, MD | <input type="checkbox"/> Nicolas Zea, MD |
| <input type="checkbox"/> Stephen M. Settle, MD | <input type="checkbox"/> Jeffrey M. Apple, MD | <input type="checkbox"/> Ryan S. Turley, 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
- History & Physical
- Recent Progress/Office Note
- Medication List

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

Preferred Hospital: _____

When Completed, Please Fax to 866.591.1084