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CHI Memorial
Vascular Surgery Specialists
DIALYSIS REFERRAL FORM

 **423-654-7670**

 **423-654-7671**

Please fax demographics, insurance cards, office note(s) and imaging along with referral form to 423-654-7671 *If referral is for new access, please include vein mapping order.

Nephrologist/ Referring provider:		Contact name:	
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Contact phone:		Contact Fax:	
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Patient's name:		DOB:	
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Mailing address:			
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Current Access None Catheter Fistula Graft

Previous Access AVF AVG PermCath Date placed _____

Access location RUE LUE Surgeon _____

Does the patient require transportation Yes No If yes, # of days notice needed _____

Is the patient currently in a skilled nursing facility? Yes No

Reason for referral ***please check all that apply**

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Initial Vascular referral | <input type="checkbox"/> Elevated venous pressure | <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Difficult cannulation | <input type="checkbox"/> Multiple sticks | <input type="checkbox"/> Prolonged bleeding | |
| <input type="checkbox"/> Inadequate flow | <input type="checkbox"/> Clot aspiration | <input type="checkbox"/> Abnormal labs | |

Request for: Office visit Fistulogram Ultrasound New Access Other _____

If you do not receive a fax back from us within 48-72 hours, please call our office at 423-654-7670 to ensure receipt of fax. Our scheduler will fax a confirmation back to the referring contact above, after the patient is scheduled or if the patient is unable to be scheduled.