Indiana Surgery & Vascular Center
a division of IKS

REFERRAL FORM

5540 S. East Street Suite 100, Indianapolis, IN 46227
Phone: 317-634-0920 • Fax: 317-634-0921

IF THIS IS A TIME SENSITIVE REQUEST, PLEASE CALL THE CENTER DIRECTLY.
****INCOMPLETE FORMS AND/OR MISSING INFORMATION MAY DELAY THE SCHEDULING PROCESS****

TODAY'S DATE:_____ **REQUESTED DATE:**_____

FULL NAME : _____

DOB : _____

ADDRESS : _____

CITY, STATE ZIP : _____

PHONE : _____

DIALYSIS CENTER : _____

LAST DATE OF SUCCESSFUL DIALYSIS:_____

PATIENT REGULAR DIALYSIS DAYS:

☐ M-W-F ☐ T-T-S ☐ M-F

☐ AM ☐ MID ☐ PM

PLEASE FAX THE FOLLOWING INFORMATION TO OUR OFFICE:

DEMOGRAPHIC SHEET MEDICATION LIST
INSURANCE CARD(S)

ACCESS TYPE Location: LT or RT

☐ AVG ☐ PAVF ☐ AVF ☐ No Access ☐ Vein Mapping (specify surgeon) _____

☐ Catheter Location: ☐ Chest LT or RT ☐ Groin LT or RT

☐ PD Consult ☐ PD Exchange ☐ PD Placement ☐ PD Removal ☐ PD Repositioning

INDICATION:

☐ **Abnormal Bruit/Thrill** ☐ **Aneurysm** ☐ **Broken** ☐ **Clotted** ☐ **Decreased Access Flow** ☐ **Difficult Cannulation**

☐ **Exchange** ☐ **High Venous Pressure** ☐ **Infection** ☐ **Infiltration** ☐ **New Placement** ☐ **No Longer Needed**

☐ **Non Maturing Fistula** ☐ **Office Visit** ☐ **Painful** ☐ **Poor Arterial Pressure** ☐ **Poor Function** ☐ **Poor Kt/v Clearance**

☐ **Prolonged Bleeding** ☐ **Recirculation** ☐ **Repair** ☐ **Steal Syndrome** ☐ **Swelling** ☐ **Other:** _____

CLINICAL INFORMATION

Contrast or IV Dye allergy?

☐ Yes Reaction_____

☐ No ☐ Prep Ordered

Diabetic?

☐ Yes ☐ No

Anticoagulants:

☐ Coumadin ☐ Plavix ☐ Eliquis

☐ Brilinta ☐ N/A ☐ Other: _____

Competent to sign consent?

☐ Yes ☐ No

Whom: _____ Phone: _____

Last Two Access Flow or DVP Readings (Required)

Reading: _____ Date: _____

Reading: _____ Date: _____

TRANSPORTATION

Can patient provide own transportation to and from facility?

☐ Yes ☐ Needs transportation

DIALYSIS CENTER

Referring Physician:_____ Nephrologist:_____ Surgeon:_____

Phone:_____ Fax:_____ Scheduled By:_____