HVAC Humble Vascular Access Center
9810 FM 1960 Bypass Rd. W. Suite#165
Humble, Texas 77338
John Nguyen, DO

REFERRAL FORM

PH 281-570-2575
Fax 281-570-2579
Ruchdi Barakat, MD

HVSC Humble Vascular Surgical Center
8411 FM 1960 Bypass Rd. W. Ste A
Humble, Texas 77338
Brett Stephens, MD

Today's Date:_____ Requested procedure date:_____

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Patient Phone No.: (Home) _____ (Cell) _____

Dialysis Schedule: ❑ M W F ❑ T T S Shift: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Nocturnal ❑ PD

ISOLATION PRECAUTIONS: ❑ Yes ❑ No Type:_____

Access Procedure: •AV Graft / •AV Fistula

Type of Access: ❑ AV Graft ❑ AV Fistula Placement Date:_____

Location: ❑ Right / ❑ Left ❑ Forearm ❑ Upper Arm ❑ Chest ❑ Thigh

Desired Procedure: ❑ Declot ❑ Fistulogram/Graftogram ❑ Venogram ❑ AVF Creation
❑ *Other* _____

Indication:
- ❑ High Venous Pressure/Arterial Pressure
- ❑ Difficult Cannulation
- ❑ Pulling Clots
- ❑ Prolonged Bleeding
- ❑ Recirculation
- ❑ Non Maturing Fistula
- ❑ Pain
- ❑ Swollen Extremity
- ❑ Infiltration
- ❑ Access Surveillance
- ❑ Permanent Access
- ❑ Clotted Access
- ❑ Steal Syndrome
- ❑ Aneurysm

Catheter Procedure:

Site: ❑ Tunneled / ❑ Non-Tunneled ❑ Right / ❑ Left ❑ Chest ❑ Groin ❑ Abdomen

Desired Procedure: ❑ Insertion ❑ Catheter Change ❑ Removal ❑ PD Catheter Consult ❑ PD Catheter Placement

Indication:
- ❑ Poor Function
- ❑ No Longer Required
- ❑ Infection
- ❑ New Patient/Modality Change
- ❑ Broken Catheter
- ❑ Clotted Catheter
- ❑ Painful Catheter
- ❑ Exchange temporary catheter for permanent catheter
- ❑ *Other* _____

Clinical Information:

X-Ray Contrast Allergy? ❑ Yes ❑ No ❑ Reaction?_____

Diabetic? ❑ Yes ❑ No

Any Anticoagulants? ❑ Coumadin ❑ Plavix ❑ ASA ❑ *Other* _____

Competent to sign consent? ❑ Yes ❑ No: If No, Whom?_____ Phone_____

Transportation Needs:

Will patient provide own transportation? ❑ Yes ❑ No ❑ HVAC/HVSC Arranged Transportation

❑ Ambulatory ❑ Cane ❑ Walker ❑ Wheel Chair ❑ Stretcher

Post - Procedure Destination: ❑ Home ❑ Dialysis Clinic ❑ *Other* _____

Dialysis Center: Please fill out the following information in full.

Referred by:_____ Phone:_____ Fax:_____

Nephrologist:_____ Dialysis unit:_____

If the patient is confused or forgetful, a second signature is *REQUIRED:* _____

ALL OF THE FOLLOWING MUST BE FAXED TO OUR OFFICE:

1. Insurance Cards
2. Pt. Demographic Sheet
3. Medication List
4. Most Recent H&P
5. Most Recent Hemoglobin & Potassium Levels

Please notify our office if the patient has current infection and/or is hepatitis positive.

HVAC/HVSC use only *Appointment Date/Time:*_____ *Pickup Time:*_____ *Confirmed By:*_____