EMIS | Elite Minimally Invasive Specialists

Patient Referral Form

Patient Name: _____

DOB: _____

Patient Address: _____

Patient Phone: _____

Patient Insurance: _____

Referring Physician: _____

Dialysis Center: _____

Dialysis Phone & Fax Number: _____

Access Site:

○ LT / ○ RT **Fistulagram / Graft** ○ LT / ○ RT **Catheter**

Reason For Referral:

○ Declot ○ Difficult Cannulation ○ Steal Syndrome ○ Prolonged Bleeding

○ High Venous Pressure ○ Swollen Extremity ○ Non-Maturing Fistula ○ Infiltration

○ Recirculation ○ Declining Arterial Flow ○ Aneurysm ○ Clot Aspiration ○ Venogram

○ PD Cath Placement ○ CVC Placement ○ CVC Removal ○ PAD ○ Venous Insufficiency

○ CVC Exchange Due To: _____

○ Other: _____

PLEASE ATTACH PATIENT:
DEMOGRAPHIC SHEET, RECENT H&P, DIAGNOSTIC IMAGES, LABS (INCLUDING COAGULATION), MEDICATION LIST, INSURANCE CARDS

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