PREFERRED VASCULAR GROUP

Access Referral Form

PVG Southeast Atlanta Vascular Care
5461 Hillandale Drive, Suite 210, Lithonia, GA 31201
P: 770.981.8477, **F: 770.981.8908**

Required Fields

*Today's Date _____ *Completed By: _____

*Patient Name: _____ *DOB: _____

*Address: _____ *Dialysis Schedule: ☐ MWF ☐ TTS

*Phone No.: _____ *Shift ☐ 1 ☐ 2 ☐ 3 ☐ 4

*Dialysis Center: _____ *Last Dialysis Treatment: _____

*Nephrologist: _____ *Dialysis Phone: _____ *Dialysis Fax: _____

*Skilled Nursing Facility (SNF): ☐ Yes ☐ No *SNF Name: _____ *SNF Phone: _____

*Hospice Patient: ☐ Yes ☐ No *Hospice Name: _____ *Hospice Phone: _____

*Access Type: ☐ Graft ☐ Fistula ☐ Catheter *Access Location: ☐ Right ☐ Chest ☐ Forearm ☐ Upper Arm ☐ Left ☐ Thigh ☐ Groin

Date of Creation: _____ Surgeon: _____ * Service Requested: ☐ Evaluate and Treat

AVG/AVG Indication:

☐ Clotted Access - Date Clotted: ☐ Cold/Numbness/Paid ☐ Recirculation ☐ Infiltration

☐ High Venous Pressure ☐ Non-Maturing Fistula ☐ Aneurysm ☐ Low BFR ☐ Difficult Cannulation

☐ Abnormal Functional Studies ☐ Low Kt/V ☐ Weak Thrill/Bruit ☐ Prolonged Bleeding ☐ Swollen Extremity Studies

☐ High Arterial Pressure ☐ Other/Describe:

Catheter Procedure Requested:

Date of Insertion: _____ Facility Where Placed: _____

Type: ☐ Tunneled ☐ Non-tunneled Site: ☐ Right ☐ Left ☐ IJ ☐ Groin ☐ Subclavian

Indication: ☐ Clotted ☐ Poor Function ☐ Broken Catheter ☐ No Longer Required ☐ Exchange temporary catheter for permanent catheter

☐ Other/Describe:

Desired Procedure: ☐ Insertion ☐ Catheter Exchange ☐ Removal

Clinical Information:

X-Ray Contrast Allergy? ☐ Yes ☐ No Reaction/Describe: _____

Diabetic? ☐ Yes ☐ No If yes, is the patient on insulin? ☐ Yes ☐ No

Anticoagulants? ☐ Yes ☐ No If yes, what type? _____

Competent to Sign Consent? ☐ Yes ☐ No If no, then whom? _____

Is the patient ambulatory? ☐ Yes ☐ No Wheelchair? ☐ Yes ☐ No Stretcher? ☐ Yes ☐ No

FOLLOW UP CARE COORDINATION REQUEST

1. The Referring Physician Practice ("Practice") and Southeast Atlanta Vascular Care ("PVG") acknowledge that there is a significant need in the Atlanta community ("Community") for a comprehensive, high quality, accessible, cost-effective, and coordinated approach for the delivery of care to ESRD patients.
2. Practice and PVG desire to manage and coordinate care services for ESRD patients by offering coordinated care delivery and care coordination programs to assist with managing and improve care coordination and outcomes for ESRD patients which will specifically address reduction in potentially avoidable rehospitalization, reduction in unnecessary emergency department utilization and appropriate care strategies for ESRD patients that include vascular access services provided by PVG.
3. Practice requests that PVG provide: (a) ongoing assessment of the vascular access of the patient as determined to be medically necessary by Practice and/or PVG; (b) medically necessary and clinically appropriate medical interventions to address any vascular issues that materially affect a patient's ability to receive dialysis services; and (c) timely updates to Practice of all services provided by PVG to Practice's patients.

Signature:	Name:	Verbal or Fax Order received from:

Please fax form with demographics, insurance information, H&P and current medication list.