NAADI Healthcare
Vascular and Interventional 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

○ Venous Insufficiency ○ Vein Mapping / Dialysis Access Creation ○ Peripheral Arterial Disease

○ CVC Exchange Due To:

○ Other:

Please Attach Patient's:

Demographic Sheet, Recent H&P, Labs, Medication List, Insurance Information, Insurance Cards, Advanced Directive, POA, and any patient DNR Instructions

Phone Number: (209) 788-8180
Fax Number: (209) 783-0036

145 Trevino Ave Manteca, CA 95337

Thank You For The Opportunity To Participate In Your Patient's Health Care