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