METHODIST SURGERY CENTER – RICHARDSON
Dr. Suresh Margassery
3001 E. President George Bush Hwy
Ste 150
Richardson, TX 75082

DVC
Dallas Vascular Center
PH: 214-943-1687 | FAX: 214-943-9373

ADVANCED SURGICAL CENTER
Dr. Suresh Margassery
1018 E. Wheatland Rd
Duncanville, TX 75116

THIS FORM IS AN OFFICIAL REQUEST FOR TREATMENT AND SERVES AS A PHYSICIAN'S ORDER

DIALYSIS PATIENT REFERRAL / APPOINTMENT REQUEST

1 PLEASE SELECT YOUR PREFERRED FACILITY

◯ **METHODIST SURGERY CENTER – RICHARDSON**
Dr. Suresh Margassery
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Ste 150,
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◯ **ADVANCED SURGICAL CENTER**
Dr. Suresh Margassery
1018 E. Wheatland Rd,
Duncanville, TX 75116

2 PATIENT INFORMATION

PATIENT NAME _____ **DATE OF BIRTH** _____

PATIENT PHONE _____ **DIALYSIS CENTER** _____ **PHONE NUMBER** _____

SCHEDULE: ☐ MWF ☐ TTS | **SHIFT:** ☐ 1 ☐ 2 ☐ 3 ☐ Nocturnal ☐ Home Hemo

3 REFERRING PROVIDER

REFERRING PHYSICIAN _____ **NURSE NAME** _____ **PHONE** _____

NURSE SIGNATURE _____ **DATE** _____

4 PROCEDURE REQUESTED & INDICATIONS — *Check one procedure and one or more indications as appropriate*

PROCEDURE REQUESTED

FISTULA / GRAFT
- ☐ Angiogram / Fistulogram
- ☐ Declot / Thrombectomy

ULTRASOUND PROCEDURES
- ☐ Vessel Mapping
- ☐ Ultrasound / Doppler

HD CATHETER
- ☐ Catheter Placement
- ☐ Catheter Exchange
- ☐ Catheter Removal

INDICATIONS
- ☐ Increased Arterial Pressure
- ☐ Increased Venous Pressure
- ☐ Pulsatile Graft / Fistula
- ☐ Prolonged Bleeding
- ☐ Decreased URR or Kt/V
  - ☐ URR < 65%
  - ☐ Kt/V < 1.2
- ☐ Low Access Flow
- ☐ Non-Maturing Access
- ☐ Access Maturity Eval
- ☐ Non-Functioning Catheter
- ☐ Catheter Exposed / Damaged
- ☐ Infection

INDICATIONS (CONT'D)
- ☐ Clotted Access
- ☐ Difficult Cannulation
- ☐ Possible Stenosis
- ☐ Weak Extremity Pulse
- ☐ Pain
- ☐ Swelling
- ☐ Infection
- ☐ Pulling Clots
- ☐ Aneurysm
- ☐ Other: _____

5 ACCESS INFORMATION (CIRCLE ALL THAT APPLY)

TYPE OF ACCESS	◯ A/V FISTULA		◯ GRAFT		◯ CATHETER
LOCATION	◯ UPPER ARM	◯ FOREARM	◯ IJ	◯ SUBCLAVIAN / CHEST	◯ FEMORAL
SIDE	◯ LEFT		◯ RIGHT		

6 IMPORTANT REMINDERS

Please FAX a copy of the following to DVC along with this referral form:

1. **Facesheet**
2. **Medication List**
3. **Most Recent H&P**
4. **Most Recent Insurance Information**

Please give the patient his/her copy of the PATIENT APPOINTMENT INSTRUCTIONS provided by DVC.

THANK YOU FOR YOUR REFERRAL. WE APPRECIATE YOUR TRUST AND PARTNERSHIP IN PATIENT CARE.