Cardiothoracic and Vascular Surgeons

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Kyle, TX 78640
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www.ctvstexas.com

ESRD/Dialysis Referral Form

If this is an urgent matter, please call our office

Patient Name: ____________________

Patient Address:____________________

City:____________________ State:__________ Zip:__________

Phone (_______) ____________________ Email Address:____________________

SSN: ________ - ________ - ________ Date of Birth:____________________

Nephrologist OR Referring Physician:

____

Is patient in a nursing home? ☐ Yes ☐ No

Nursing Home Name: ____________________

Phone (_______) ______________

Referral to see:

☐ First Available OR Please check one of the boxes below

☐ John K. Politz, MD
☐ Stephen M. Settle, MD
☐ Joe K. Wells, MD
☐ Scott A. Seidel, MD
☐ Jeffrey M. Apple, MD
☐ Bradley A. Boone, MD
☐ David A. Nation, MD
☐ Ryan S. Turley, MD
☐ Taylor A. Smith, MD
☐ Nicolas Zea, MD
☐ Kofi B. Quaye, MD

Dialysis Information:

Is patient on dialysis? ☐ Yes ☐ No

If yes, method of dialysis: ☐ Fistula/Graft ☐ PD Cath ☐ Perm Cath

If yes, first date of dialysis:____________________

Dialysis Unit:____________________ Phone (_______) ______________ Contact Name:____________________

Dialysis Days: ☐ Mon/Wed/Fri ☐ Tues/Thurs/Sat ☐ Other:____________________

Reason for referral:

☐ Fistula/Graft: Creation OR Problem:____________________

☐ PD Cath: Placement OR Problem:____________________

☐ Permcath: Placement OR Problem:____________________

☐ Other____________________

Please send with all referrals:

- **Demographics/Insurance**
- **Recent Progress/Office Note**
- **History & Physical**
- **Medication List**

Without the above information, scheduling the patient will be delayed.

Preferred Hospital: ____________________

When Completed, Please Fax to 866.591.1084