



HOURS OF OPERATION:
 Monday - Friday: 8:00 am - 5:00 pm
Saturday: 9:00 am - 2:00 pm

9701 Richmond, Suite 150
 Houston, TX 77042
 Tel: 713-980-7840
 Fax: 713-980-7843

Referral Form

Today's Date: _____ Requested Procedure date: _____

Patient Name: _____ Patient Weight _____

Patient address below is: Patient's Actual Home Patient's Nursing Home (select physical address of patient)

Street Address _____

City _____ State _____ Zip Code _____

Telephone (Patient/Nursing Home) _____ Dialysis Treatment _____

- | | |
|--|--|
| <input type="checkbox"/> Vein treatment | <input type="checkbox"/> Lumbar ESI |
| <input type="checkbox"/> Peripheral angiogram/angioplasty/stenting | <input type="checkbox"/> IVC filter |
| <input type="checkbox"/> Port placement (chest or arm) | <input type="checkbox"/> DVT treatment |
| <input type="checkbox"/> PICC line | <input type="checkbox"/> Uterine artery embolization |
| <input type="checkbox"/> Kyphoplasty/vertebroplasty | |

- | | |
|--|--|
| <input type="checkbox"/> Thyroid FNA | <input type="checkbox"/> Ultrasound guided paracentesis |
| <input type="checkbox"/> Breast biopsy | <input type="checkbox"/> Ultrasound guided thoracentesis |
| <input type="checkbox"/> Bone marrow biopsy | <input type="checkbox"/> Transjugular liver biopsy |
| <input type="checkbox"/> Other image guided biopsy
(specify location _____) | <input type="checkbox"/> Lumbar puncture |

- | | |
|--|---|
| <input type="checkbox"/> Dialysis fistula/graft declot | <input type="checkbox"/> Non-tunneled (temporary) dialysis catheter |
| <input type="checkbox"/> AV fistulogram/graftogram | <input type="checkbox"/> Dialysis catheter exchange |
| <input type="checkbox"/> Venogram | <input type="checkbox"/> Dialysis catheter removal |
| <input type="checkbox"/> Tunneled dialysis catheter | |

OTHER (specify) _____

Referred Center _____ Phone _____ Fax _____

Referred by _____ Specialty _____

Phone Number _____ Fax Number _____

Primary Insurance _____ Policy No _____ D.O.B. _____

Secondary Insurance _____ Policy No _____ S.S.N. _____

Dr. Signature _____

Pre-procedure Instructions for the Patient

- 1 Please let AVIC know at least 24 hours before your procedure **ahead of time** if you have any known allergies.
- 2 Please be NPO for the procedure (nothing to eat or drink for 6 hours before the scheduled procedure time).
- 3 You may take your physician prescribed medications pre-procedure, with a small amount of water, ***EXCEPT for the following blood thinners: Coumadin (Warfarin), Plavix, Aspirin, and Lovenox.***
- 4 Please bring a list of all current medications with you to your appointment.
- 5 If you are taking diabetic medications - please call ahead to AVIC for specific instructions.
- 6 Please bring your insurance cards with you to your appointment.