Carolina Vascular Care
30 Azimuth Court
Rocky Mount, NC - 27804
Phone: (252) 220-5470
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Patient Scheduling/Order Form

Last Name:_____ **First Name:**_____ **DOB:**_____

Patient Phone:_____ **Patient Address:**_____

Primary Insurance:

Secondary Insurance:

Clinical History/Reason for Exam:

Referring Physician/Provider: _____ **Referring Provider Signature:** _____

Dialysis Clinic:_____ **Dialysis Clinic Phone:**_____ **Dialysis Clinic Fax:**_____

Dialysis Shift (Circle One): **M/W/F** **T/TH/S** **Home HD** **PD**

Today's Date:_____ **Requested Date:**_____

Procedure/s Requested:

Dialysis Access Maintenance

Dialysis Catheter •	Circle one:	**Removal**	**Exchange**	**Placement**	Side/Location:
PORT Catheter •	Circle one:	**Removal**	**Exchange**	**Placement**	Side/Location:

Evaluate and Treat Dialysis Fistula	☐	Side/Location:
Evaluate and Treat Dialysis Graft	☐	Side/Location:
PD Catheter Manipulation	☐	Side/Location:
Peritoneal Catheter Placement	☐	Side/Location:

Assessment and Creation of Percutaneous AV fistula (Including Vein Mapping) ☐

Patient Details

X-Ray Contrast Allergy? ☐ **Yes** ☐ **No** **Reaction?**_____

Competent to Sign Consent? ☐ **Yes** ☐ **No**

If No, who will sign? **Name**_____ **Relation**_____ **Phone Number**_____

Patient Transportation: ☐ **Patient Arranged Transport** ☐ **CVC Arranged Transport**

Please fax the following to our office (along with this form):
1. Insurance Cards
2. Patient Demographic Sheet
3. Medication List
4. Most Recent H&P