Dialysis Center Referral Form

Date: _____ Referring Provider: _____

Patient Name: _____ Referring Provider Phone Number: _____

Patient DOB: _____ Referring Provider Fax Number: _____

Patient E-Mail: _____

Patient Phone Number: _____

Patient Insurance: _____

☐ Evaluate AV Fistula ☐ Thrombolysis of AV Fistula

☐ Permacath Placement ☐ Permacath Removal

☐ Request a procedure/Other: _____

SUBMIT THE FOLLOWING DOCUMENTATION WITH REFERRAL:

- Demographics Sheet
- Copy of Insurance Card
- Most recent surveillance US of AV Fistula (If applicable)

REFERRING PROVIDER SIGNATURE: _____

5683 S Rex Road
Memphis, TN 38119

1720 East Reelfoot Avenue
Union City, TN 38261

To refer to either location, please call 662-775-0114 or fax this form to 662-775-0666