TEXAS ADVANCED SURGERY CENTER

Mohammad Ali Saeed, M.D.
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6927 Brisbane Ct STE 100
Sugar Land, TX 7747

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

****PLEASE FAX CURRENT PATIENT INFO, INSURANCE CARD(s) MEDICATION LIST, LABS, H&P WITH THIS REFERRAL** FAX: 713-980-7843**

**Referral Form** Today's Date: _____ Requested Procedure date: _____

Patient Name: _____ D.O.B.: _____

Patient address below: □ Patient's Home (NO PO Box) □ Patient's Nursing Home

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: □ Patient _____home / cell / work □ Nursing Home _____

**DIALYSIS TREATMENT DAYS: □ MWF □ TTS SHIFT: □ 1 □ 2 □ 3 □ 4 □ NOCTURNAL □ PD**

**LAST DIALYSIS TREATMENT (if applicable)**_____ **ISOLATION PRECAUTIONS:** □ Yes □ No (Type): _____

**Access Location:** □ Right □ Left □ Forearm □ Upper Arm □ Chest □ Thigh □ Abdomen

## Access Procedure:

□ AV Fistula/Graft Declot
□ AV Fistula/Graft Evaluation
□ New AV Fistula Creation
□ Venous Mapping
□ Tunneled Catheter Placement
□ Tunneled Catheter Exchange
□ Tunneled Catheter Removal
□ Percutaneous Fistula Creation
□ Peripheral Arterial Disease – Eval & treat
□ Venous Insufficiency – Eval & treat

## Indication for Procedure:

□ Access Surveillance
□ High Venous Pressure/Arterial Pressure
□ Swollen/Painful Extremity
□ Low Access Flow
□ Difficult cannulation
□ CVC Access No Longer Required
□ Recirculation
□ Clotted Access
□ Access Malfunction
□ Steal Syndrome
□ Pain/Swelling in limb
□ Aneurysm
□ Prolonged Bleeding
□ Infiltration
□ History of PVD
□ Non-healing wound
□ Pulling Clots
□ Non-Maturing Fistula
□ Abnormal ABI
□ Limb Ischemia
□ Gangrene

## Clinical Information

**X-Ray Contrast Allergy**? □ Yes □ No Reaction? _____
**Diabetic** □ Yes □ No **Anticoagulants**? □ Coumadin □ Plavix □ ASA □ Other _____
**Competent to sign consent? □ Yes □ No** **If NO, who?** _____ **Phone** _____

## Transportation (Dialysis/PAD Patients only)

**Will patient provide own transportation**? □ Yes □ No □ AVIC Arranged Transportation

□ Ambulatory □ Cane □ Walker □ Wheel Chair □ Stretcher
Post Procedure Destination □ Home □ Dialysis Clinic □ Other _____

**Referring Center**: _____Phone: _____Fax:_____

**Referring physician**: _____

**TASC use only** Appointment Date/Time: _____Pickup Time: _____Confirmed By: _____