



Peter Gregory, MD

Aparna Baheti, MD

Laura Slee, ARNP

Date: _____

Patient Information

Name _____
Date of birth _____
Primary number _____
Secondary number _____
Insurance name _____
Insurance ID _____

Provider & Unit Information

Unit name _____
Unit Phone number _____
Treatment Days _____
Transportation _____
Provider _____

Central Venous Access

PROCEDURE

- New Placement
- Exchange
- Removal
- Repair
- Declot / Thrombolysis
- Dye Study

Clinical Indications(s)

- Chemotherapy / Infusions
- IV Access
- Infection
- Poor Flow
- Pain
- Other _____

Allergies: _____

Additional Comments: _____

Yes No

- Allergy to IV Contrast Dye? _____
- Able to Sign Informed Consents? _____
- Translator required? _____
- Transportation Arranged? _____

PLEASE FAX REFERRAL TO 253-874-1923
WITH DEMOGRAPHICS, INSURANCE
INFORMATION, RECENT LAB RESULTS &
MEDICATION LIST

Not sure what to order? Call 253-874-7107 to speak with our staff.

Thank you for this referral!

