Phone: 866.797.9535
Fax: 781.894.0404
procedure@firstresponsevc.com

First Response
Vascular Access Clinic

Medical Building
20 Hope Avenue, Suite 204
Waltham, MA 02453

Referring Physician

Physician Name: _____ Today's Date: _____

NPI #: _____ Referral #: _____

Phone #: _____ Fax #: _____

Patient Demographics

Patient Name: _____ ☐ Male ☐ Female

DOB: _____ Age: _____ Height: _____ Weight: _____

SSN: _____ Parent / Guardian: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____ Contact Phone: _____

Diagnosis: (Select all that apply)

☐ Sepsis	☐ Cancer	☐ Chronic Renal Failure	☐ Other _____
☐ Pneumonia	☐ Osteomyelitis	☐ Lime	☐ Other _____
☐ Cellulitis	☐ Diabetes	☐ CVA	☐ Other _____

Allergies: ☐ Heparin ☐ Lidocaine ☐ Chlorhexidine ☐ Latex Other: _____

History: ☐ Breast Cancer ☐ Diabetes ☐ Pacemaker Placement ☐ Previous Central Line ☐ COPD

☐ CVA/Stroke ☐ left or ☐ right sided deficit ☐ Renal ☐ Hemodialysis catheter - where: _____

Other History: _____

Insurance Information

Subscriber: _____ Insurance: _____

Policy#: _____ Group#: _____

Guarantor: _____ Guarantor DOB _____

Vascular Access Orders *(check all that apply)*

☐ PICC Line Placement | ☐ Midline Placement | ☐ Chest X-Ray for Line Placement | ☐ Lidocaine

Medications intended for Line ☐ Antibiotics ☐ Chemo ☐ Fluids ☐ Solumedrol ☐ Nutrition ☐ other _____

Please Provide the Following: ☐ Current Labs ☐ Patient History

Physician Signature _____ Date #: _____ Time #: _____

Signature