DIALYSIS ACCESS MANAGEMENT

REFERRAL FORM

Today's Date: _____ Patient Name: _____

DOB: _____ Telephone: _____

Street Address: _____

City: _____ State:_____ Zip Code: _____

Access Type:
❑ AV Graft

❑AV Fistula
❑ Other

Location:
❑Right
❑Left
❑Forearm
❑Upper arm
❑Other_____

Indication:
❑Clotted Access
❑Prolonged Bleeding
❑Infiltration
❑Difficult Cannulation
❑High Venous Pressures
❑Transonic Monitoring
❑Low Access Flow Rate
❑Recirculation
❑Aneurysm
❑Swollen Extremity
❑Non-maturing AVF
❑Steal Syndrome

Desired Procedure
❑ Declot
❑ Fistulagram/Graftogram
❑ Collateral Vein Ligation
❑ I.V. Vein Mapping
❑ Other

Catheter procedure
❑ Tunneled
❑ Non- Tunneled

Location:
❑ Right
❑ Left

Indication:
❑ Clotted Catheter
❑ Poor Function
❑ Infection
❑ No Longer Required
❑ Exchange Temporary

Desired Procedure
❑ Declot
❑ Fistulagram/Graftogram
❑ Collateral Vein Ligation
❑ I.V. Vein Mapping
❑ Other

Referring Physician: _____ Phone: _____

Please fax the following :

New Patient:
__ Referral Form __ Demographics
__ H&P __ Medication List

Current Patient:
__ Referral Form
__ Updated Medication List

DIALYSIS CENTER

Referred Center: _____ Phone: _____

Nephrologist: _____ Fax: _____

Referred by (print and title): _____ Initials: _____

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