Referral Form (Page 1)

NS SURGICAL CENTER

Dialysis days MWF/TTS, Shift: 1st, 2nd, 3rd Todays date: ___-_____20_________

PLEASE PRINT AND COMPLETE ALL INFORMATION ON FORM

Is patient a resident of a nursing home? No ☐ Yes ☐ If "Yes", please use nursing home address and phone number (below).

Patient Name: ____

Patient Address: ____

Patient Phone No.: ______-______-________ Last Dialysis Treatment: ____-____-______

☐ AV Graft / ☐ AV Fistula Date of Creation: ____-____-____ Surgeon____________________________

Location: ☐ Right / ☐ Left ☐ Forearm / ☐ Upper Arm ☐ Chest/ ☐ Thigh

Desired Procedure: ☐ Thrombectomy/Clotted ☐ Fistulogram/Graftogram

Indication: ☐ Clotted Access (NO Thrill and NO Bruit) ☐ Decreased adequacy ☐ Non Maturing Fistula

☐ Infiltration ☐ High Venous Pressure ☐ Transonic Monitoring

☐ Prolonged Bleeding ☐ Difficult Cannulation ☐ Negative Arterial Pressure

☐ Recirculation ☐ Swollen Extremity ☐ Aneurysm o Other ________________________

Site: ☐ Tunneled / ☐ Non-Tunneled ☐ Right / ☐ Left ☐ I J / ☐ Groin ☐ Subclavian

Date of Insertion: ____-____-________

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal

Indication: ☐ Clotted [☐ Poor Function ☐ Infection Y/N Cultures obtained Y/N,Type__________If Yes, Result__________________

☐ Broken Catheter ☐ No Longer Required due to (please circle): Mature Access/Recovered Function/Change of Modality

☐ Exchange temporary catheter for permanent catheter o Cuff exposed o Catheter Fell out

Clinical Information: MUST COMPLETE THIS SECTION

Current Treatment for Infection_____________________ Date initiated__________________

☐ Infection/Type ☐MRSA ☐C Difficile ☐VRE ☐ Bed Bugs ☐ Bloodborne Type______________Isolation Y/N____________________

X-Ray Contrast Allergy? …………… ☐ Yes ☐ No ☐ Reaction? ____

Diabetic? …………………………….. ☐ Yes ☐ No

Anticoagulation Medications ……….☐ Yes ☐ No (complete referral page 2)

Competent to Sign Consent? ….…… ☐ Yes ☐ No ….. If "No", by Whom? ____________________ Phone: ______-______-________

Transportation Needs: Does Patient have own transportation? ☐ Yes ☐ No

☐ Company ____ Phone ______-______-________

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher or Hoyer Lift

☐ Transportation arranged by Dialysis Clinic o Yes o No

Post-procedure Destination: ☐ Home ☐ Dialysis Clinic (Time: _________) ☐ Other _____________________________

Dialysis Center: _____________________________________ Phone: ______-______-________ Fax: ______-______-________

Scheduled by: ______________________ Nephrologist: ___________________________ Surgeon: ___________________________

Insurance Info: Patient D.O.B: ______-______-__________ Patient S.S.N.: ________- ______-__________

Primary Insurance: ____ Policy No.: ________________________________

Secondary Insurance: ____ Policy No.: ________________________________

Referring Physician's Signature, if available:____

Referral Completed by: (Verbal Order – Nurse) ____________________________ Date:___________

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

NS Surgical Center ● 10 E. Cambridge Circle Drive ● Suite 150 ● Kansas City, KS 66103
Phone: 913-233-0454 ● Fax: 913-233-0649

For access center use only. **Appointment Date/Time: ____-____-20____ @ ____:____ Pickup Time: ____:____ Confirmed By: ___**

NS Surgical Center
10 E. Cambridge Circle Drive, Suite 150
Kansas City, KS 66103
Phone: (913) 233-0454 Fax: (913) 233-0649

Patient name________________________________ **Date of Birth**____________________

Is the patient currently taking any of the following medications? *(please confirm with the patient or caregiver directly on the day this referral is completed and faxed**)**

(Coumadin) / warfarin / (Jantoven) / (Marevan) / (Lawarin) / (Waran):

(please circle medication) Yes/No

(Lovenox) enoxaparin) / (Fragmin) dalteparin / (Innohep) tinzaparin / Normiflow (ardeparin) (please circle medication) Yes/No

(Plavix) clopidogrel / (Ticlid) ticlopidine / (Effient) prasugrel / (Brilinta) ticagrelor

(please circle medication) Yes/No

(Xarelto) rivaroxaban / (Arixtra) fondaparinux

(please circle medication) Yes/No

(Eliquis) apixaban / (Oragarn) danaparoid / (Angiomax) bivalirudin / Pradaxa) dabigatran Argatroban /

(please circle medication) Yes/No

List the current dose of the medication circled above: __________________

List the name and phone number of the physician who prescribed the medication and/or is managing the specific medication dosing and monitoring.

Physician Name________________________________ Phone number______________________

Obtain the most recent INR or aPTT.

Date of draw________________ Location of draw___________________

Phone number ____________________________

INR result___________________PTT result____________________ (Please report N/A if not applicable)