Dialysis Access Centers

Michigan Kidney Consultants P.C.

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REFERRAL FORM

Date_____

Patient Name_____ D.O.B._____

SS#_____ Home Phone #_____

Home Address_____

Dialysis Unit_____ Phone #_____ Fax #_____

Nephrologist_____ Scheduler_____

Please Include

*H&P *Demographics *Insurance Information *Current Medication List ❑ Isolation Patient

- **Dialysis Days and Shift**
  - o M W F o T TH S 1st 2nd 3rd
- **Access Type and Location**
  - o Right / Left
  - o Fistula / Graft / Catheter
  - o Arm / Thigh / Chest
- **Please Choose Reason for Referral**
  - o Thrombectomy / Declot (no buit or thrill) _____
  - o Angiogram / Angioplasty _____ Indication _____
  - o Catheter Insertion _____ Removal_____ Exchange_____
  - o Vessel / Vein Mapping _____
  - o Antiobiotic Catheter Insertion_____ Removal_____
  - o New Patient Consultation / Access Placement Consult _____
    - Please include recent vein map if applicable
  - o Post OP Follow Up _____
  - o Surgical Evaluation _____
  - o Other _____
  - o Does Patient need transportation? o Yes o No
  - o Does Patient have a contrast allergy? o Yes o No
  - o Is Patient on anticoagulants? o Yes o No

Referring Physician's Signature, if available:_____

Referral Completed by: (Verbal Order – Nurse) _____ **Date**: _____