



Access Center Referral Form

Patient Name: _____ DOB: _____ Patient Phone #: _____

Dialysis Center: _____ Nephrologist: _____

Referral Completed By: _____ Contact Phone #: _____ Date: _____

Check box if: Patient resides at a SNF?

Check box if: Patient transports by stretcher?

Please Include

CURRENT DEMOGRAPHICS PATIENT REVIEW H&P {IF NEW PT}

HMO AUTHORIZATION IF NEEDED DVP PRINT OUT FOR THIS MONTH AND LAST MONTH

DIALYSIS TREATMENT INFORMATION:

MWF TTS TREATMENT ON TIME: _____

REASON FOR REFERRAL:

- THROMBECTOMY (CLOTTED ACCESS)
- ASSESSMENT OF FISTULA (ASSESS FOR USE)
- VESSEL MAPPING
- CATHETER EXCHANGE
- CATHETER REMOVAL
- CATHETER PLACEMENT
- ANGIOGRAM/FISTULAGRAM (PLEASE MARK INDICATION BELOW)
 - NON- MATURE
 - DIFFICULT CANNULATION
 - BLEEDING
 - LOW KT/V
 - LOW TRANSONIC CURRENT _____ Prior _____
 - ANEURYSM
 - SWOLLEN EXTREMITY
 - HIGH VENOUS PRESSURE
 - OTHER _____

ACCESS SIDE: LEFT RIGHT

ACCESS TYPE: FISTULA GRAFT CATHETER

Referring Physician's Signature, if available: _____

Referral Completed by: (Verbal Order – Nurse) _____

FOR AFTER HOURS EMERGENCIES CALL HOTLINE (TM ONLY NUMBER)