

**Dialysis Access Center
of Southeast Michigan**

REFERRAL FORM

Today's Date: _____

| | |
|---|--|
| Is this patient a resident of a nursing home? Y N | If yes, please use nursing home address and phone number. |
|---|--|

Patient Name: _____

Phone: _____

Patient Address: _____

Patient D.O.B: _____

Patient S.S.N: _____ - _____ - _____

| | |
|--|--|
| <p>ACCESS TYPE: Date of Creation/Insertion: _____</p> <p><input type="checkbox"/> Graft <input type="checkbox"/> Fistula <input type="checkbox"/> Catheter <input type="checkbox"/> None</p> <p><input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Forearm <input type="checkbox"/> Upper Arm <input type="checkbox"/> IJ <input type="checkbox"/> Groin</p> <p><input type="checkbox"/> Subclavian <input type="checkbox"/> Thigh <input type="checkbox"/> Peritoneal</p> | <p>Dialysis Days: MWF TTS</p> <p>Times: _____</p> <p>Last Dialysis Treatment: _____</p> <p>Next Dialysis Treatment: _____</p> <p>Would the patient mind being scheduled on a dialysis day? Y N</p> |
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DESIRED PROCEDURE:

Declot Angiogram/ Angioplasty Vein Mapping Catheter Insertion Catheter Exchange

Catheter Removal Catheter Repair Other _____

Indication:

Clotted Access Steal Syndrome Non Maturing Fistula Prolonged Bleeding Follow up

Difficult Cannulation Recirculation Swollen Extremity Aneurysm Infection

Infiltration Transonic monitoring Clotted Catheter Broken Catheter Poor Function

No Longer Required High Venous Pressure High Arterial Pressure Exchange Temporary Catheter for Permanent

Other _____

| | |
|--|--|
| <p>CLINICAL INFORMATION</p> <p>X-Ray Contrast Allergy? Y N VRE/MRSA positive? Y N</p> <p><input type="checkbox"/> Reaction _____</p> <p>Diabetic? Y N Coumadin/Other Lytics? Y N</p> <p>Is the patient competent to sign consent? Y N</p> <p>If "no", Whom? _____</p> <p>Phone: _____</p> | <p>INSURANCE INFORMATION:</p> <p>Primary Insurance: _____</p> <p>Policy#: _____</p> <p>Secondary Insurance: _____</p> <p>Policy#: _____</p> <p>The patient is:</p> <p><input type="checkbox"/> Ambulatory <input type="checkbox"/> Cane <input type="checkbox"/> Walker</p> <p><input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher</p> |
|--|--|

Dialysis Center: _____ **Phone:** _____ **Fax:** _____

Scheduled by: _____ **Nephrologist:** _____ **Surgeon:** _____

Referring Physician's Signature, if available: _____

Referral Completed by: (Verbal Order – Nurse) _____

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:
 Dialysis Access Center of Southeast Michigan • 2890 Washtenaw Avenue • Ypsilanti, MI 48197-1507
 Phone: 734-528-9433 Fax: 734-528-9455