# Valley
Access Center

## Referral Form
Please Print All Information

□ **Patient will call to schedule**     □ **VAC to call and schedule**

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

Patient Name: _____

Patient Phone No.: ____ - ____ - _____     Patient D.O.B- ___/___/___     Patient S.S.N.: _____

Dialysis Days:     Mon/Wed/Fri     Tues/Thurs/Sat     Nocturnal     Last Dialysis Treatment: -_____

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**Access Type:**     o AV Graft / o AV Fistula     o Catheter     Date of Creation:____ - ____ - _____

**Location**:     o Right / o Left     o Forearm / o Upper Arm     o Chest / o Thigh

**Desired Procedure:**     o Declot     o Fistulogram/Graftogram     o Venogram     o Ultrasound     o Other _____

**Indication:**     o Clotted Access     o Steal Syndrome     o Non Maturing Fistula

o Infiltration     o High Venous Pressure     o Decreases Flow **(Please attach Flow sheet)**

o Prolonged Bleeding     o Difficult Cannulation     o Follow-up

o Recirculation     o Swollen Extremity     o Aneurysm

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**Catheter Procedure**

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

Date of Insertion:     ____ - ____ - _____

Desired Procedure:     o Insertion     o Catheter Change     o Removal

Indication:     o Clotted Catheter     o Poor Function     o Infection

o Broken Catheter     o No Longer Required     o Other _____

o Exchange temporary catheter for permanent catheter

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**Clinical Information:**

X-Ray Contrast Allergy?............ o Yes     o No     o Reaction -     o Rash     o Dyspnea     o Anaphylaxis

Diabetic?................................... .. o Yes     o No     o Other Allergies _____

Hemoglobin (gm/dl):_____     Date Taken: _____

Coumadin/Eliquis/Xarelto/Other Lytics?...... o Yes     o No     Last INR:_____     Date Taken: _____

Competent to Sign Consent?....... o Yes     o No     .. If "No", Whom?_____     Phone:____ - ____ - _____

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**New Access:**     □ Upper Extremity Vessel Mapping for AVF Creation. Image and evaluate veins and arteries.

Hospital Preference _____

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**Transportation Needs**     Does Patient have own transportation?     o Yes     o No

o Company_____     Phone____ - ____ - _____

o     Ambulatory  o Cane     o Walker     o Wheelchair     o Stretcher

Access Center Arranged Transport: Company:_____     Phone____ - ____ - _____

Post- Procedure Destination: o Home     o Dialysis     o Other _____

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**Dialysis Center:**     Clinic: _____     Phone: ____ - ____ - _____     Fax: ____ - ____ - _____

Scheduled by: _____     Nephrologist: _____     Surgeon: _____

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**Referring Physician's Signature, if available:**_____

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

**Please fax completed form with Patient Demographic info, Insurance Card(s), Medication List, Dialysis Access Flow & Lab Flow Sheet** to:

**Valley Kidney Specialists, P.C. I 2014 City Line Road, Suite 101 I Bethlehem, PA 18017**
**Phone: 610-264-5199 I Fax: 610-264-5198**