KIDNEY SPECIALISTS SURGICAL CENTER

REFERRAL FORM
7326 W Cheyenne. Suite 110, Las Vegas, NV 89129
P: (702) 258-0078
F: (702) 870-0731

Today's Date: _____

***COMPLETE ENTIRE FORM, FAX WITH DEMOGRAPHICS, I.D. & INSURANCE CARD, MED LIST, H&P, AND LABS**

PATIENT NAME: _____ DOB: _____SSN: _____

ADDRESS: _____ PHONE: _____

PRIMARY INSURANCE _____ POLICY NUMBER: _____

SECONDARY INSURANCE _____ POLICY NUMBER: _____

RESIDENT OF NURSING HOME? YES NO IF YES NAME & NUMBER: _____
COMPETENT TO SIGN? YES NO IF NO P.O.A. NAME & NUMBER: _____
ON ANTICOAGULANTS? YES NO IF YES, WHAT DRUG? _____
CURRENTLY ON ANTIBIOTICS? YES NO
CONTRAST OR IODINE ALLERGY? YES NO

REASON FOR REFERRAL

CIRCLE ACCESS SITE, PROCEDURE AND INDICATION

CATHETER

RIGHT/LEFT

CHEST/GROIN

EXCHANGE
- ○ BROKEN CATHETER
- ○ CLOTTED
- ○ EXPOSED CUFF
- ○ POOR FUNCTION

REMOVAL
- ○ NO LONGER ON HD
- ○ TRANSITIONED TO PD
- ○ USING GRAFT/FISTULA

PLACEMENT
- ○ CATHETER FELL OUT
- ○ CATHETER INFECTED
- ○ INITIATION OF HD
- ○ OTHER:_____

AV ACCESS

RIGHT/LEFT

ARM/THIGH

GRAFT/FISTULA

ANGIOGRAM
- ○ ANEURYSM
- ○ CHECK MATURATION
- CREATION DATE: _____
- SURGEON: _____
- ○ DECREASED KT/V/URR
- ○ DIFFICULT CANNULATION
- ○ HIGH VENOUS PRESSURE
- ○ INFILTRATION
- ○ NEGATIVE ARTERIAL PRESSURE
- ○ NON-MATURING FISTULA
- ○ PAIN
- ○ PROLONGED BLEEDING
- ○ RECIRCULATION
- ○ STEAL SYNDROME
- ○ SWOLLEN EXTREMITY
- ○ TRANSONICS
- ○ OTHER:_____

DECLOT
- ○ CLOTTED ACCESS

VESSEL MAPPING
- ○ NO EXISTING GRAFT/FISTULA
- ○ GRAFT/FISTULA FAILURE
- ○ PD CATH FAILURE

DIALYSIS CENTER:_____ HD DAYS: MWF/TTS SHIFT TIME:_____

SCHEDULED BY: _____ NEPHROLOGIST:_____
(Verbal order-RN) (Print name & credentials) (Referring physician signature if available)

For access center use only----------> Appointment Date: _____-_____-_____ @ Time:_____