

Referral Form (Page 1)

NS SURGICAL CENTER

Dialysis days MWF/TTS, Shift: 1st, 2nd, 3rd Todays date: ___ - ___ 20___

PLEASE PRINT AND COMPLETE ALL INFORMATION ON FORM

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

Patient Name: _____

Patient Address: _____

Patient Phone No.: _____ - _____ - _____ Last Dialysis Treatment: _____ - _____ - _____

AV Graft / AV Fistula Date of Creation: _____ - _____ - _____ Surgeon _____

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

Desired Procedure: Thrombectomy/Clotted Fistulogram/Graftogram

Indication: Clotted Access (NO Thrill and NO Bruit) Decreased adequacy Non Maturing Fistula

Infiltration High Venous Pressure Transonic Monitoring

Prolonged Bleeding Difficult Cannulation Negative Arterial Pressure

Recirculation Swollen Extremity Aneurysm o Other _____

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

Date of Insertion: _____ - _____ - _____

Desired Procedure: Insertion Catheter Change Removal

Indication: Clotted Poor Function Infection Y/N Cultures obtained Y/N, Type _____ If Yes, Result _____

Broken Catheter No Longer Required due to (please circle): Mature Access/Recovered Function/Change of Modality

Exchange temporary catheter for permanent catheter o Cuff exposed o Catheter Fell out

Clinical Information: MUST COMPLETE THIS SECTION

Current Treatment for Infection _____ Date initiated _____

Infection/Type MRSA C Difficile VRE Bed Bugs Bloodborne Type _____ Isolation Y/N _____

X-Ray Contrast Allergy? Yes No Reaction? _____

Diabetic? Yes No

Anticoagulation Medications Yes No (complete referral page 2)

Competent to Sign Consent? Yes No If "No", by Whom? _____ Phone: _____ - _____ - _____

Transportation Needs: Does Patient have own transportation? Yes No

Company _____ Phone _____ - _____ - _____

Ambulatory Cane Walker Wheelchair Stretcher or Hoyer Lift

Transportation arranged by Dialysis Clinic o Yes o No

Post-procedure Destination: Home Dialysis Clinic (Time: _____) Other _____

Dialysis Center: _____ Phone: _____ - _____ - _____ Fax: _____ - _____ - _____

Scheduled by: _____ Nephrologist: _____ Surgeon: _____

Insurance Info: Patient D.O.B: _____ - _____ - _____ Patient S.S.N.: _____ - _____ - _____

Primary Insurance: _____ Policy No.: _____

Secondary Insurance: _____ Policy No.: _____

Referring Physician's Signature, if available: _____

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

Please fax completed form along with Patient Demographic sheet, Insurance Card(s) & Medication List to:

NS Surgical Center • 10 E. Cambridge Circle Drive • Suite 150 • Kansas City, KS 66103

Phone: 913-233-0454 • Fax: 913-233-0649

For access center use only. Appointment Date/Time: _____ - _____ -20 _____ @ _____: _____ Pickup Time: _____: _____ Confirmed By: _____

NS Surgical Center
10 E. Cambridge Circle Drive, Suite 150
Kansas City, KS 66103
Phone: (913) 233-0454 Fax: (913) 233-0649

Referral Form (Page 2)

Patient name _____ Date of Birth _____

Is the patient currently taking any of the following medications? *(please confirm with the patient or caregiver directly on the day this referral is completed and faxed)

(Coumadin) / warfarin / (Jantoven) / (Marevan) / (Lawarin) / (Waran):

(please circle medication) Yes/No

(Lovenox) enoxaparin / (Fragmin) dalteparin / (Innohep) tinzaparin / Normiflow (ardeparin) (please circle medication) Yes/No

(Plavix) clopidogrel / (Ticlid) ticlopidine / (Effient) prasugrel / (Brilinta) ticagrelor

(please circle medication) Yes/No

(Xarelto) rivaroxaban / (Arixtra) fondaparinux

(please circle medication) Yes/No

(Eliquis) apixaban / (Oragarn) danaparoid / (Angiomax) bivalirudin / Pradaxa) dabigatran Argatroban /

(please circle medication) Yes/No

List the current dose of the medication circled above: _____

List the name and phone number of the physician who prescribed the medication and/or is managing the specific medication dosing and monitoring.

Physician Name _____ Phone number _____

Obtain the most recent INR or aPTT.

Date of draw _____ Location of draw _____

Phone number _____

INR result _____ PTT result _____ (Please report N/A if not applicable)