

**VASCULAR CENTER
OF WICHITA NEPHROLOGY**

2122 N. Garnett Street
Wichita, KS 67206
PHONE (316) 636-1234 / (888) 588-2630
FAX (316) 636-2630

REFERRAL SHEET

PATIENT NAME _____ DOB _____ SS# _____

HOME ADDRESS OR PLACE OF RESIDENCE _____

PHONE (home) _____ (mobile) _____ (other) _____

NEPHROLOGIST _____ VASCULAR SURGEON _____

DIALYSIS UNIT _____ PT SCHEDULE: MWF TThS

TYPE OF ACCESS _____ LOCATION OF ACCESS _____

DATE OF ACCESS CREATION _____ PT HEIGHT _____ PT WEIGHT _____

HAS ACCESS BEEN REVISED _____ DATE OF REVISION _____ SURGEON _____

REFERRING PHYSICIAN'S SIGNATURE, IF AVAILABLE: _____

REFERRAL COMPLETED BY: (VERBAL ORDER – NURSE) _____

INSURANCE *no longer accept Medicaid patients

PRIMARY INSURANCE _____ POLICY# _____ GROUP# _____

SECONDARY INSURANCE _____ POLICY# _____ GROUP# _____

REASON FOR REFERRAL

- () BLEEDING
- () DIFFICULT CANNULATION
- () INFILTRATION
- () POOR AUMENTATION
- () SWOLLEN ARM
- () SWELLING/ ANEURYSM ON ACCESS
- () REDNESS OVER ACCESS
- () DRAINAGE/ PUS
- () PAIN/ TENDERNESS OVER ACCESS
- () PAIN IN ACCESS ARM/ HAND
- () WOUND OVER ACCESS OR HAND
- () ACCESS DOES NOT COLLAPSE
- () HIGH PITCHED BRUIT/ WHISTLE SOUND

- () ASSESS NEW AV FISTULA
- () PULLING CLOTS
- () CLOTTED ACCESS
- () POSITIVE BLOOD CULTURES
- () OTHER _____

- POOR FLOW _____ ml/min
- POOR TRANSONIC _____ ml/min
- HIGH ARTERIAL PRESSURE _____ ml/min
- HIGH VENOUS PRESSURE _____ ml/min
- RECIRCULATION _____ %
- OTHER _____
