RNA
Rockford Nephrology Dialysis Access Services

John C. Maynard, MD
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Access Center Referral Form

Patient Name:_____ DOB:_____ Patient Phone #:_____

Dialysis Center:_____ Nephrologist:_____

Referral Completed By: _____ Contact Phone #:_____ Date:_____

Check box if: Patient resides at a SNF? ☐ **Check box If: Patient transports by stretcher?** ☐

Please Include

CURRENT DEMOGRAPHICS PATIENT REVIEW H&P {IF NEW PT)

HMO AUTHORIZATION IF NEEDED DVP PRINT OUT FOR THIS MONTH AND LAST MONTH

DIALYSIS TREATMENT INFORMATION:

☐ MWF ☐ TTS TREATMENT ON TIME:_____

REASON FOR REFERRAL:

- ☐ THROMBECTOMY (CLOTTED ACCESS)
- ☐ ASSESSMENT OF FISTULA (ASSESS FOR USE)
- ☐ VESSEL MAPPING
- ☐ CATHETER EXCHANGE
- ☐ CATHETER REMOVAL
- ☐ CATHETER PLACEMENT
- ☐ ANGIOGRAM/FISTULAGRAM (PLEASE MARK INDICATION BELOW)
  - ☐ NON- MATURE
  - ☐ DIFFICULT CANNULATION
  - ☐ BLEEDING
  - ☐ LOW KT/V
  - ☐ LOW TRANSONIC CURRENT_____ Prior_____
  - ☐ ANEURYSM
  - ☐ SWOLLEN EXTREMITY
  - ☐ HIGH VENOUS PRESSURE
  - ☐ OTHER _____

ACCESS SIDE: ☐ LEFT ☐ RIGHT

ACCESS TYPE: ☐ FISTULA ☐ GRAFT ☐ CATHETER

Referring Physician's Signature, if available:_____

Referral Completed by: (Verbal Order – Nurse) _____

FOR AFTER HOURS EMERGENCIES CALL HOTLINE (TM ONLY NUMBER)

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