Dialysis Access Center of Southeast Michigan

REFERRAL FORM

Today's Date:_____

Is this patient a resident of a nursing home? Y N **If yes, please use nursing home address and phone number.**

Patient Name:_____ Phone:_____

Patient Address: _____

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

ACCESS TYPE: Date of Creation/Insertion:_____

☐Graft ☐Fistula ☐Catheter ☐None

☐Right ☐ Left

☐Forearm ☐Upper Arm ☐ IJ ☐ Groin

☐ Subclavian ☐ Thigh ☐ Peritoneal

Dialysis Days: MWF TTS

Times: _____

Last Dialysis Treatment: _____

Next Dialysis Treatment: _____

Would the patient mind being scheduled on a dialysis day?

Y N

DESIRED PROCEDURE:

☐Declot ☐Angiogram/ Angioplasty ☐Vein Mapping ☐Catheter Insertion ☐Catheter Exchange

☐Catheter Removal ☐Catheter Repair ☐Other _____

Indication:

☐Clotted Access ☐Steal Syndrome ☐Non Maturing Fistula ☐Prolonged Bleeding ☐Follow up

☐Difficult Cannulation ☐Recirculation ☐Swollen Extremity ☐Aneurysm ☐Infection

☐Infiltration ☐Transonic monitoring ☐Clotted Catheter ☐Broken Catheter ☐Poor Function

☐No Longer Required ☐High Venous Pressure ☐High Arterial Pressure ☐Exchange Temporary Catheter for Permanent

☐Other _____

CLINICAL INFORMATION

X-Ray Contrast Allergy? Y N VRE/MRSA positive? Y N

☐Reaction _____

Diabetic? Y N Coumadin/Other Lytics? Y N

Is the patient competent to sign consent? Y N

If"no", Whom? _____

Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy#: _____

Secondary Insurance: _____

Policy#: _____

The patient is:

☐Ambulatory ☐Cane ☐Walker

☐Wheelchair ☐Stretcher

Dialysis Center:_____ Phone:_____ Fax:_____

Scheduled by:_____ Nephrologist:_____ Surgeon:_____

Referring Physician's Signature, if available:_____

Referral Completed by: (Verbal Order – Nurse) _____

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

Dialysis Access Center of Southeast Michigan• 2890 Washtenaw Avenue• Ypsilanti, MI 48197-1507

Phone: 734-528-9433 Fax: 734-528-9455