Norwood
4805 Montgomery Rd, Suite 140
Cincinnati, OH 45212
(513) 631-4555 Phone
(513) 631-5546 Fax

DIALYSIS ACCESS CENTER OF CINCINNATI

Referral Form - Please Print All Information

Liberty
7335 Yankee Rd, Suite 101
Liberty Township, OH 45044
(513) 779-8111 Phone
(513) 779-8999 Fax

Patient name: _____ **Date:** _____

Patient Address: _____

Resident of Nursing Home: ☐ **Yes** ☐ **No** **Facility Name:** _____ **Phone:** _____

Patient Phone: _____ **Patient DOB:** _____

Patient SSN: _____ **Mode of Transportation:** _____

Primary Insurance: _____ **Policy No.:** _____

Secondary Insurance: _____ **Policy No.:** _____

Access Type Being Worked on:

☐ AV Graft ☐ AV Fistula ☐ No Existing Access ☐ Catheter ☐ PD Catheter ☐ Port-a-cath

Body Location:

☐ Right ☐ Left ☐ Arm ☐ Thigh ☐ Chest ☐ Abdomen

Date of Creation: _____ Surgeon: _____

Desired Procedure:

AVF / AVG: ☐ Declot ☐ Vessel Mapping ☐ Fistulogram/Graftogram

HD Catheter/Port: ☐ Placement ☐ Exchange ☐ Repair ☐ Removal

PD Catheter: ☐ Placement ☐ Reposition/Replace ☐ Removal

Indication:

☐ Aneurysm ☐ Broken Catheter ☐ Clotted ☐ Difficult Cannulation
☐ Exposed Cuff ☐ Infection ☐ Infiltration ☐ Initiation of Dialysis
☐ High Venous Pressure ☐ Low Kt/V / URR ☐ No longer required ☐ Non-Maturing Fistula
☐ Pain ☐ Poor Blood Flow ☐ Prolonged Bleeding ☐ Recirculation
☐ Steal Syndrome ☐ Swollen Extremity ☐ Abnormal Surveillance ☐ Vascular Access
☐ Negative Art Pressure ☐ Vasc Alert Risk Score 7-8-9-10 (circle one & send Vasc Alert)
☐ Other: _____

Clinical Information:

Dialysis Center Name: _____ Phone: _____

Last Dialysis Treatment: _____ Dry Weight: _____

Dialysis Days: ☐ Monday, Wednesday, Friday ☐ Tuesday, Thursday, Saturday

Allergies:

Contrast / Iodine / Shellfish ☐ Yes ☐ No Reaction: _____

ChlorPrep/ Chlorhexidine ☐ Yes ☐ No Reaction: _____

Heparin ☐ Yes ☐ No Reaction: _____

Lidocaine ☐ Yes ☐ No Reaction: _____

Coumadin / Warfarin: ☐ Yes ☐ No PT / INR _____ Date: _____

Other Blood Thinner(s): _____

Primary Language: _____ **Interpreter Required**: ☐ Yes ☐ No

Competent to sign consent: ☐ Yes ☐ No If "No", POA _____ Phone: _____

Verbal Order – Nurse Signature: _____ **Nephrologist**: _____

Referring Physician (and Signature, if available): _____

Please fax completed form along with Patient Demographic Sheet, Insurance Card(s), Medication List, Labs, H & P and Infectious Disease Status.

Revised: June 2023 klb