HEMODIALYSIS ACCESS REFERRAL: EXISTING ACCESS

Date: ____/____/____ Referred to ☐ Interventional radiologist/nephrologist ☐ Surgeon
Dr.________________________ Phone #: ______________ Fax #: ________________

HEMODIALYSIS UNIT CONTACTS

Referring Nephrologist: ______________________ Phone #: ____________________ Fax #: ________________
Referring Dialysis Unit : __________________ Contact Person: ________________ Phone #: ______________ Fax #: ________________

PATIENT DEMOGRAPHICS

Patient's Name ____________________________ SS# ______________________ DOB _____/_____/_____
Address ____________________________ City ________________ State _____ Zip _____
Patient's Phone ________________ Emergency Contact ______________________ Phone ________________
Insurance ____________________________ Phone ______________

REASON FOR REFERRAL AND PROCEDURE REQUESTED

Reason ____
Procedure/Evaluation Requested ____
Desired Access ____
Date of Scheduled Procedure (If known) ____/____/____ Location: ____

CURRENT ACCESS

Type: ☐Fistula ☐Graft ☐Catheter ☐Port **Side:** ☐Left ☐Right **Extremity:** ☐Arm ☐Leg
Location: ☐Upper ☐Lower ☐ IJ ☐Other
Access Insertion Date: ____/____/____ Surgeon ______________________ Hospital ______________________

Most Recent Access Blood Flow Rates/Pressures: (Check all that apply)

- ☐ Most recent Blood Flow Rate _____ cc/min.
- ☐ Most recent Static Venous Pressure (SVP) _____
- ☐ Most recent Dynamic Venous Pressure _____
- ☐ Most recent Arterial Pressure _____

Recent Surgical/Radiologic Interventions to Access:
1. ________________________________ Date____/____/____ Physician ______________________
2. ________________________________ Date____/____/____ Physician ______________________

Recent Access Problems/Complication - Check all that apply:

- ☐ Difficult cannulation
- ☐ Pain in extremity
- ☐ Severe swelling/extremity
- ☐ Hematoma/Infiltration
- ☐ Infected Access
- ☐ High venous pressure
- ☐ Change in bruit or thrill
- ☐ ↓ URR or Kt/V
- ☐ Possible Steal Syndrome
- ☐ Pseudoaneurysm
- ☐ Prolonged bleeding during/after dialysis
- ☐ Problems with arterial flow
- ☐ Other (Specify) ________________________

SYNOPSIS OF MEDICAL HISTORY

	Yes	No
SEAFOOD OR DYE ALLERGIES * - if yes, fistulagram may be contraindicated → contact Nephrologist	☐	☐
Diabetes	☐	☐
Peripheral Vascular Disease	☐	☐
History of Clotted Access	☐	☐
Anticoagulation Medicines - If yes ✓ specific medicine(s) below	☐	☐
☐Coumadin ☐Ticlid ☐ASA ☐Plavix ☐Other-list :	☐	☐
Recent PT/PTT – if yes, results:	☐	☐
Recent CBC	☐	☐
Recent Chest x-ray	☐	☐
Recent EKG	☐	☐
Other pertinent medical history:		

DIALYSIS TREATMENT INFORMATION

Patient's Dialysis Schedule: ☐ M-W-F ☐ T-Th-S on **am / midday / pm** shift Date of Last Dialysis___/___/___
Weight today:_____________ Estimated Dry Weight: ________________ Last time patient ate or drank: ________________________
Stat K+ drawn @ ___:_____am/pm on ___/___/___ → __________meq/dl.
Transportation Service ______________________________________ Phone______________________

Comments:

VASCULAR ACCESS DIAGRAM – FAX to Dialysis Facility and/or Nephrologist

Patient Name:____ Procedure Date:____________

Diagram Completed by: ☐ Surgeon ☐ Interventional Radiologist ☐ Interventional Nephrologist

Name (Surgeon or Interventionalist):__________________________ Phone: (_____) ____________________

FAX to: ☐ Nephrologist Name:____________________________ FAX #: (_____) ____________________

☐ Facility Name:____________________________ FAX #: (_____) ____________________

Procedure(s): (Check all that apply)	**Access Type**	**Configuration**	**Location**
SURGERY ☐ New Access ☐ Thrombectomy ☐ Revision ☐ Other- specify: ____________________ **INTERVENTIONAL (Endovascular)** ☐ Thrombolysis / Thrombectomy ☐ PTA ☐ Stent ☐ Catheter insertion or revision ☐ Diagnostic Fistulogram only ☐ Other- specify: ____________________	☐ A/V Graft ☐ A/V Fistula ☐ Port device ☐ Central venous Catheter If new catheter, priming volume: ________ml ☐ Cuffed ☐ Non-cuffed **Graft Material *(if applicable)*** ☐ PTFE ☐ Other – specify: ________________ ________________	**Graft *(if applicable)*** ☐ Loop ☐ Straight ☐ Curved **Fistula Construction *(if applicable)*** ☐ Radio-cephalic ☐ Brachio-cephalic ☐ Transposed Type: ____________ ________________ ________________ ☐ Other – specify: ________________	☐ Right ☐ Left ☐ Forearm ☐ Upper arm ☐ Leg/Thigh ☐ Other—specify: ________________ ☐ Subclavian ☐ Internal Jugular ☐ Femoral ☐ Other – specify: ________________

NOTE: Please show Configuration of access, Vessels Involved, and Direction of Access Flow

NOTES:

Were diagnostic evaluations performed prior to procedure? If yes, describe: --

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Brief description of procedure (if preferred access not placed, explain reason): --

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Procedure findings (if relevant): --

Was procedure successful? Yes No (circle one)

Recommendations/Comments: --

Additional care information/instructions: --

Special cannulation instructions: --

Patient follow-up:

1. Patient to schedule appointment with Surgeon/Nephrologist (circle one) in ___ days/weeks (circle one).
2. Patient appointment has been scheduled ________(date) with Dr. ______________

Other Notes: --