HEMODIALYSIS ACCESS REFERRAL: NEW ACCESS

Date: ____________

Referred **to** (Surgeon): ____________ Phone #: ____________ Fax #: ____________

Referred **by** (Nephrologist): ____________ Phone #: ____________ Fax #: ____________

PATIENT DEMOGRAPHICS

Patient's Name ____________ SS# ____________ DOB ____/____/____

Address ____________ City ____________ State _____ Zip _____

Patient's Phone ____________ Emergency Contact ____________ Phone ____________

Insurance ____________ Phone ____________

TO BE COMPLETED BY NEPHROLOGIST (attach med list / labs if applicable)

Our patient is being referred to you for access placement. The desired access for this patient is:

- ☐ **fistula**
- ☐ graft
- ☐ central cath
- ☐ other: ____________

In the event you are not planning to place the desired access, please call the referring physician *prior* to placing *any* other access

Site preference:

☐ Right ☐ Left

- ☐ upper arm
- ☐ lower arm
- ☐ thigh
- ☐ chest
- ☐ other: ____________

IF AV fistula:

- ☐ radial-cephalic
- ☐ brachial-cephalic
- ☐ transposed: Vein type: ____________
- ☐ other: ____________

If Catheter:

- ☐ IJ vein
- ☐ SC vein
- ☐ Femoral **vein**
- ☐ other: ____________

Diagnostic evals pre-referral: ☐ No ☐ Yes: date/result: ____________ (attach)

The anticipated dialysis start date is: ☐ ____________

Most recent GFR or serum creatinine: ____________ mg/dl Date: ____________

Most recent creatinine clearance: ____________ ml/min Date: ____________

Taking Coumadin or other Anti-Coagulant? ☐ Yes ☐ No

Allergy Alert:

If patient has any dye or seafood allergies, fistulagram may be contraindicated. Contact Nephrologist for orders re: patient's plan of care.
Allergies: ☐ Yes ☐ No List all Allergies: ____________

Comments / Additional information:

SURGEON:

- **PLEASE FILL OUT THE "VASCULAR ACCESS DIAGRAM" AND FAX TO NEPHROLOGIST and/or DIALYSIS FACILITY**

NEPHROLOGIST:

- **PLEASE FAX THIS FORM, ALONG WITH THE COMPLETED "VASCULAR ACCESS DIAGRAM" TO THE DIALYSIS FACILITY.**

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: ------------------------

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

Procedure findings (if relevant): ------------------------

Was procedure successful? Yes No (circle one)

Recommendations/Comments: ------------------------

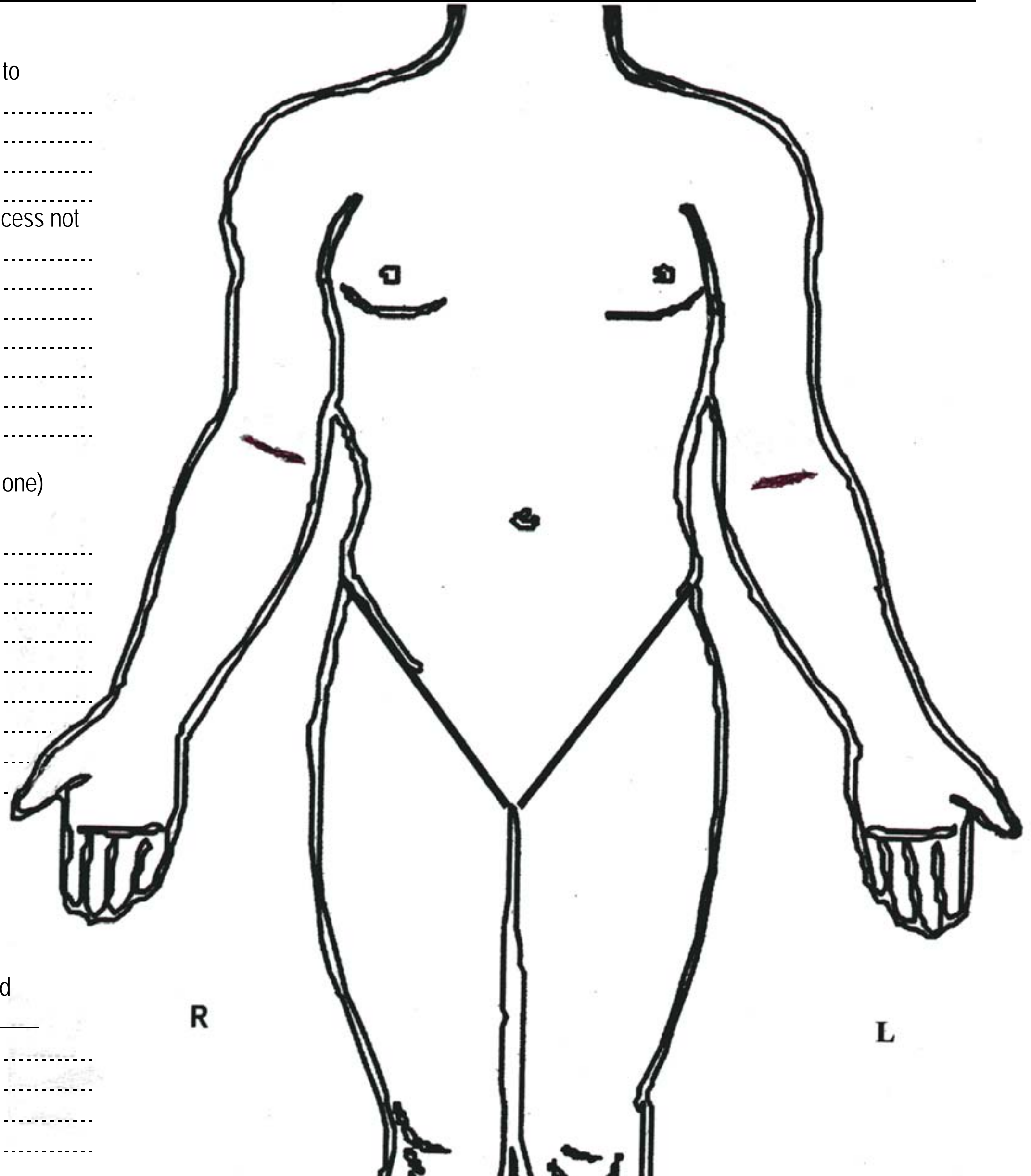
Additional care information/instructions: ------------------------

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: ------------------------



Patient's Consent for Disclosure of Medical Information (Use if Applicable)

Date: ______________________________

I, ___________________________________ Date of Birth: ________________
(type or print name of patient)

do hereby consent that you **release to:**

- ☐ Nephrologist: ____________________
- ☐ Surgeon: ____________________
- ☐ Radiologist: ____________________
- ☐ Dialysis Facility: ____________________

(Name or title of the person(s) or organization(s) **to** which disclosure is to be made)

confidential medical, psychiatric, and/ or psychological records **in the custody of :**

- ☐ Nephrologist: ____________________
- ☐ Surgeon: ____________________
- ☐ Radiologist: ____________________
- ☐ Dialysis Facility: ____________________
- ☐ Hospital: ____________________

(Name or title of the person(s) or organization(s) **from** which disclosure is to be made)

General nature of information to be released and dates: Any and all information pertaining to dialysis access placement, dialysis treatments during hospitalization and general hospitalization records requested e.g., interventional radiological reports, operative reports, discharge / follow-up information, lab work, x-rays
Additional : ____________________

This consent shall be in effect for ninety (90) days from the date recorded on this consent. I understand that this consent is subject to revocation at any time, upon written notification by me, except to the extent that action has been taken in reliance thereon. A photocopy or facsimile of this consent is as valid as the original.

______________________________ ____________________
Signature of Patient (or guardian) Date

______________________________ ____________________
Signature of Witness Date

In the event that the patient is a minor (has not attained the age of eighteen (18) years the above consent must be executed by the patient's parent or legal guardian.