

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, fistulogram 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 <input type="checkbox"/> New Access <input type="checkbox"/> Thrombectomy <input type="checkbox"/> Revision <input type="checkbox"/> Other- specify: _____ INTERVENTIONAL (Endovascular) <input type="checkbox"/> Thrombolysis / Thrombectomy <input type="checkbox"/> PTA <input type="checkbox"/> Stent <input type="checkbox"/> Catheter insertion or revision <input type="checkbox"/> Diagnostic Fistulogram only <input type="checkbox"/> Other- specify: _____	<input type="checkbox"/> A/V Graft <input type="checkbox"/> A/V Fistula <input type="checkbox"/> Port device <input type="checkbox"/> Central venous Catheter If new catheter, priming volume: _____ ml <input type="checkbox"/> Cuffed <input type="checkbox"/> Non-cuffed Graft Material (if applicable) <input type="checkbox"/> PTFE <input type="checkbox"/> Other – specify: _____	Graft (if applicable) <input type="checkbox"/> Loop <input type="checkbox"/> Straight <input type="checkbox"/> Curved Fistula Construction (if applicable) <input type="checkbox"/> Radio-cephalic <input type="checkbox"/> Brachio-cephalic <input type="checkbox"/> Transposed Type: _____ <input type="checkbox"/> Other – specify: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Forearm <input type="checkbox"/> Upper arm <input type="checkbox"/> Leg/Thigh <input type="checkbox"/> Other—specify: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> Internal Jugular <input type="checkbox"/> Femoral <input type="checkbox"/> 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: _____

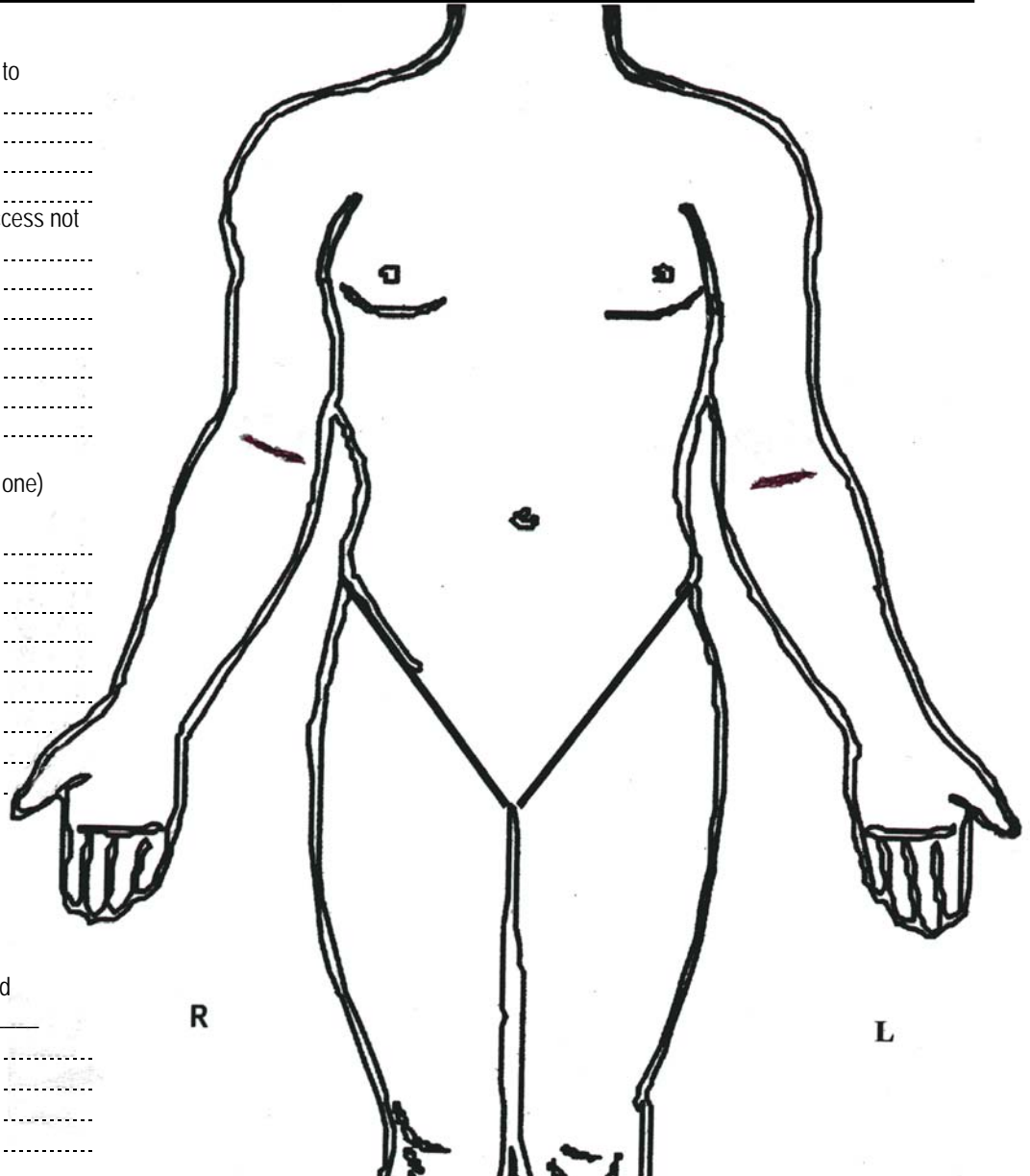
Additional care information/instructions: _____

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, _____
(type or print name of patient)

Date of Birth: _____

do hereby consent that you release to:

<input type="checkbox"/> Nephrologist: _____
<input type="checkbox"/> Surgeon: _____
<input type="checkbox"/> Radiologist: _____
<input type="checkbox"/> 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 :**

<input type="checkbox"/> Nephrologist: _____
<input type="checkbox"/> Surgeon: _____
<input type="checkbox"/> Radiologist: _____
<input type="checkbox"/> Dialysis Facility: _____
<input type="checkbox"/> 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.