

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 Dynamic Venous Pressure ___
 Most recent Static Venous Pressure (SVP) ___ 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 Hematoma/Infiltration Change in bruit or thrill Pseudoaneurysm
 Pain in extremity Infected Access ↓ URR or Kt/V Prolonged bleeding during/after dialysis
 Severe swelling/extremity High venous pressure Possible Steal Syndrome Problems with arterial flow
 Other (Specify) _____

SYNOPSIS OF MEDICAL HISTORY

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

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 <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: _____

