UMMC Dialysis Access Referral Form

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Name: _____ Date of Referral: _____

DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home/Cell #: _____ Emergency Contact: _____

Ins Co/Policy #: _____ Emergency Contact #: _____

Evaluation for New Access: (Please send any existing vein mapping, venograms or venous duplex with referral)

Desired Procedure: ☐ AV Fistula ☐ AV Graft ☐ PD Catheter ☐ Tunneled Dialysis Catheter

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Problem with Existing Access: ☐ AV Fistula ☐ AV Graft ☐ PD Catheter ☐ Tunneled Dialysis Catheter

Location: ☐ Right ☐ Left ☐ Forearm ☐ Upper Arm ☐ Chest ☐ Thigh

Desired Procedure: ☐ Venogram ☐ Declot ☐ Transposition ☐ AV access angiogram

☐ PD catheter repositioning Other: _____

Nature of problem w/ current access:

- ☐ Clotted access
- ☐ Swollen extremity
- ☐ Pain/difficult cannulation
- ☐ Pseudoaneurysm
- ☐ Non-maturing access
- ☐ Prolonged bleeding
- ☐ Infiltration
- ☐ Steal syndrome
- ☐ High venous pressure/recirculation
- ☐ Decreased flow on access surveillance
- ☐ Difficult PD drainage

Other: _____

Clinical Information:

☐ X-Ray contrast reaction? Type of Reaction: _____

Anticoagulants? ☐ Coumadin ☐ Plavix (clopidogrel) ☐ Brilinta (ticagrelor) ☐ ASA Other: _____

Dialysis information:

Center: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Type: ☐ Hemo ☐ Peritoneal Start date at current unit: _____

Dialysis Schedule: ☐ M/W/F ☐ T/Th/S ☐ Home

Referring nephrologist /provider information:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Name and phone number of person completing form: _____

Send all insurance cards (front & back), medication list, most recent labs, prior vein mapping and/or imaging to:
601-496-8130 or dialysisaccess@umc.edu.
Call 601-984-2911 with any questions.

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