

Vascular Access Referral Form

Addressograph

Date of Referral:

Referral Physician/Coordinator:

Interpreter:

- Yes
- No

Request for:

- Consult Only
- Consult and Surgery

Attachments:

- Medical and Dialysis Access History
- Medication list
- Labs

Confirm patient will need hemodialysis in future and has:

- eGFR 15-20 ml/min and Progressive CKD
- Failing PD
- Failing kidney transplant
- On hemodialysis and needs new vascular access

Allergies:

- Confirm hemodialysis is part of the patient's current or future ESKD life-Plan

Medical History:

Risk Factors for Vascular Access Failure (Select all that apply)

- Peripheral vascular disease
- Coronary artery disease
- Diabetes
- Medical history of CHF or known LV dysfunction
- BMI > 30
- Age > 65 years old
- Previous catheter use, pacemaker or other risk factors for central venous stenosis
- Previous failed fistula or graft
- Other: Click or tap here to enter text.

Prior Dialysis Access (Vascular access or PD catheter)	1	2	3
Date of Creation/insertion			
List associated complications, if any			
Current Access: <input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> AV Fistula <input type="checkbox"/> AV Graft <input type="checkbox"/> Tunneled CVC <input type="checkbox"/> Other:			
Reason for Referral			
Creation of Fistula or Graft <input type="checkbox"/> Expected hemodialysis start ≤ 6 months <input type="checkbox"/> Expected hemodialysis start > 6 months <input type="checkbox"/> Other: on dialysis		Existing Fistula and Graft <input type="checkbox"/> Maturation failure requiring revision <input type="checkbox"/> Anticipated aneurysm rupture <input type="checkbox"/> Severe limb threatening ischemia from steal syndrome <input type="checkbox"/> Thrombosis of graft/fistula <input type="checkbox"/> Infected graft/fistula <input type="checkbox"/> Other: Click or tap here to enter text.	
Other Information <input type="checkbox"/> Patient expected to self-cannulate <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed <input type="checkbox"/> Patient is on anticoagulation/antiplatelet agents <input type="checkbox"/> Others: Click or tap here to enter text.		Comments:	