Add Health Authority Logo

Add Name & Address of Vascular Access Clinic

Phone #: _____ Fax #: _____

ATTENTION: VASCULAR ACCESS NURSE

Add Addressograph/Label

REFERRAL TO VASCULAR ACCESS CLINIC

Please include: List of allergies (or copy of caution sheet), current medications, results of current blood work, current access flow measurement log, vascular access history, 3 most recent run sheets & MOST status (Medical Orders for Scope of Treatment).

Patient's Phone Number: _____

Date of referral: _____

Responsible Nephrologist:_____

Interpreter required: ☐ No ☐ Yes

If required, language: _____

Centre Referred From: _____

Renal Area Referred From:_____

☐ KCC Clinic ☐ Transplant Clinic

☐ Nephrologist's Office ☐ HD In-Centre Unit

☐ PD Clinic ☐ Community Unit

Other:_____

Hemodialysis Schedule:	☐ **Mon**	☐ **Tues**	☐ **Wed**	☐ **Thurs**	☐ **Fri**	☐ **Sat**	☐ **Sun**
Hemodialysis Time:							

Cause of Renal Failure: _____

Known Antibiotic Resistant Organisms: ☐ MRSA ☐ VRE **Infection Status**: ☐Hepatitis B ☐ Hepatitis C

Current Access:

	Left	Right	Fistula	Graft	Perm Cath	Temp Cath
Side:	☐	☐				
Location:						
Upper Arm			☐	☐		
Lower Arm			☐	☐		
Thigh			☐	☐		
Int Jugular					☐	☐
Subclavian					☐	☐
Femoral					☐	☐

Assessment for:

☐Aneurysm ☐Limb/Face Swelling

☐Clotted ☐Low Access Flow

☐Difficulty Needling ☐Pain

☐Excessive Bleeding ☐Poor Art Flow

☐High CO Failure ☐Steal Syndrome

☐High Ven Press ☐Ultrasound mapping

Other_____

_____

Reason for Referral:

☐ Fistula Creation ☐ Graft Creation

☐ Fistula Revision ☐ Graft Revision

☐ Catheter Placement

☐ Peritoneal Catheter

☐ Cuffed
☐ Non-cuffed
☐ Insertion
☐ Routine Assessment

Problem Access Creation Date: _____ **Hospital:** _____

Other relevant information (please specify):

_____

_____

Signature: _____ **Date:** _____