SVAC Southwest Vascular Access Center, S.C.

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REFERRAL FORM

Date_____

Patient Name_____ D.O.B._____

Home Phone #_____ Home Address_____

Dialysis Unit_____ Phone #_____

Fax#_____ Nephrologist_____

Referral must include H&P, insurance information, current medication list, and if they are an isolation patient.

- **Dialysis Days and Shift:** M W F T TH S 1st 2nd 3rd 4th
- **Access Type and Location:** Right/Left Fistula/Graft/Catheter Arm/Thigh/Chest
- **Reason for Referral:**

____ Thrombectomy/Declot (No bruit or thrill) **Last successful treatment**_____
____Angiogram/Angioplasty
____Catheter Insertion_____ Removal_____ Exchange_____
____Vein Mapping

Indications for referral:

- **Prolonged Bleeding**
- **Difficult Cannulation**
- **High Venous Pressure**
- **Increased Arterial Pressure**
- **Weak Bruit or Thrill**
- **Clotted Access**
- **Broken Clamp**
- **Clotted Catheter**
- **Non-Maturing Fistula**
- **Infiltration**
- **Poor Function**
- **Steal Syndrome**
- **Infection**
- **Aneurysm**
- **Swollen Extremity**
- **Other**_____

Referring Physician signature, if available_____
Referral Completed By(Verbal Order) _____