Vascular Access Referral Form

UT MEDICAL CENTER

Please complete sections A & C for all patients and fax to: 865-305-6879

A Demographics

Name:	
Date of Birth:	Referral Date:
Current Phone Number:	Procedure Date:
Insurance Information:	

B New Patient Information Only

Sex: ☐ Male ☐ Female	Race:	SS#
Address:		
City:	State:	Zip:

C Referral Information

Dialysis Clinic:		Contact:	
Dialysis Schedule: ☐ M/W/F or ☐ T/TH/S		Dialysis Start Date:	Time:
Nephrologist:		Vascular Surgeon:	
Current Access Info 1st: ☐ Fistula ☐ Graft ☐ Hero ☐ Catheter			☐ Right or ☐ Left
2nd Access: ☐ Fistula ☐ Graft ☐ Hero ☐ Catheter			☐ Right or ☐ Left

Reason for Referral:

Clotted AV Access ☐	High Venous Pressure ☐	Bleeding Non-functioning Catheter ☐
Immature AVF ☐	Edema Decreased Clearance ☐	Abnormal Flow Studies ☐
Inflow Problems ☐	Difficult Stick ☐	New Dialysis Access ☐

Allergies:	
Diabetic: ☐ Yes or ☐ No	
Anticoagulation/Antiplatelet: ☐ Yes or ☐ No	Please List:

Patient Appropriate for Permanent Access Evaluation or Peritoneal Dialysis Evaluation and may proceed with procedure after evaluation. Requires Nephrologist/Peritoneal Dialysis Signature:

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UF MEDICAL CENTER

D OFFICE USE ONLY	
Name:	Surgeon:
MR#	FIN#
CPOE Orders Done:	
Information called to:	
Brochure Faxed:	
Appointment Date/Time:	
Vein Mapping:	
Procedure:	OR#
Procedure Date/Time:	
Case#	