VACCO AMBULATORY SURGERY CENTER

Dialysis Access Referral Form

815 W. Broad St. Suite 320
Columbus, OH 43222
Phone 614.221.0222
Fax 614.221.9222

Please Fill Out All Information

Please fax completed form along with Patient Demographic Sheet, Insurance Card(s), Medication List/Allergy List.
Make sure patient is aware we will be calling to schedule and why.

Patient Name: _____ Patient Phone Number: _(_____)_____-_____

Patient Address _____

Is patient a resident of a nursing home? ☐ No ☐ Yes If "Yes", please use nursing home address and phone number.

Is the patient competent to sign? ☐ No ☐ Yes
If "No", who will sign (POA)?_____ Phone:_____

Graft / Fistula

☐ AV Graft ☐ AV Fistula ☐ HeRO Date of Creation ____/____/____ Surgeon:_____
☐ Right ☐ Left ☐ Forearm ☐ Upper Arm ☐ Thigh

Desired Procedure: ☐ Declot ☐ Fistulogram /Graftogram ☐ Vessel Mapping ☐ Other _____

Indication:
☐ Low KtV/URR ☐ No Thrill /Bruit (Declot) ☐ Non-Maturing Fistula ☐ Steal Syndrome
☐ Infiltration ☐ High Venous Pressure ☐ Prolonged Bleeding ☐ Difficult Cannulation
☐ Recirculation ☐ Swollen Extremity ☐ Aneurysm ☐ Pain
☐ Poor Blood Flow ☐ Pulling Clots (Fistulagram) ☐ Other: _____

HD Catheter Procedure

☐ Right ☐ Left ☐ IJ (Chest) ☐ Groin (Leg) Date of Insertion:____/____/_____

Desired Procedure: ☐ Placement ☐ Exchange ☐ Removal ☐ Clamp Repair

Indication: ☐ Initiation ☐ Poor Function ☐ Infection ☐ Broken Clamp
☐ Clotted Catheter ☐ Exposed Cuff ☐ No Longer Needed ☐ Other _____

PD Catheter Procedure

☐ Right ☐ Left

Desired Procedure: ☐ PD Placement ☐ Abdominal Ultrasound ☐ PD Catheter Exchange ☐ PD Catheter Removal

Indication: ☐ Initiation ☐ Change of Modality ☐ Poor Function ☐ Infection
☐ No Longer Needed

Dialysis Clinic

Clinic: _____ Phone:(____) -____-_____

Dialysis Schedule: Mon Wed Fri Tues Thurs Sat Shift _____ Last Dialysis Treatment: _____

Scheduled by: _____ Nephrologist:_____

Insurance

Patient D.O.B.:____-____-_____ Patient S.S.N.:_____-____-_____

Primary Insurance:_____ Policy No.: _____

Secondary Insurance:_____ Policy No.: _____

Verbal Order / Nurse Signature: _____ **Referring Provider:** _____

Referring Provider Signature (if available): _____**Date:**_____

Center use Only

Reviewed by : _____ *Date :* _____

Reviewed by : _____ *Date :* _____

Rev: 3/2023