

Carolina Vascular Access Referral Form

2214 Nelson Highway • Chapel Hill, NC 27517

Phone (919) 908-6080 • Fax (919) 908-6081

DIALYSIS CENTER _____

PHONE NUMBER _____

FAX NUMBER _____

M Tu W Th

F Sa Daily

1 2 3 4

Home Hemo

Nocturnal

IF ACCESS WAS PLACED WITHIN THE LAST 8 WEEKS OR PATIENT HAS HAD A SURGICAL CONSULT WITHIN THE LAST 8 WEEKS, PLEASE SEND THOSE RECORDS TO THE CVA.

Today's Date: _____ Desired Procedure Date: _____

Patient Name: _____ DOB: / /

UNC Medical Record Number (If Applicable): _____

Patient Phone: _____

Patient Address: _____

Nursing/Rehab Facility: _____

Emergency Contact: _____ Phone: _____

**ALL OF THE FOLLOWING ARE REQUIRED TO BE FAXED TO CAROLINA VASCULAR ACCESS FOR AN APPOINTMENT TO BE MADE:
• Completed Referral • Signed Order • Demographic Sheet • Medication List • Most Recent H&P • List of Allergies • Insurance Info**

ORDERING PROVIDER SIGNATURE: _____ NEPHROLOGIST: _____

IS THE PATIENT ABLE TO DIALYZE? YES NO LAST DIALYSIS TREATMENT: _____ SURGEON: _____

FISTULA OR GRAFT

TYPE OF ACCESS: Graft Fistula WHEN WAS THE ACCESS PLACED? _____

SITE/LOCATION: Right Left Forearm Upperarm Thigh HERO Graft

DESIRED PROCEDURE: Declot Fistulogram Graftogram Venagram Vessel Mapping
 Ultrasound OTHER: _____

*****If coming for maturity evaluation or is a new access, we MUST know the date the access was placed and surgeon!*****

INDICATIONS: Aneurysm High VP Low AP Pulling Clots
 Clotted Access Infiltration Recirculation
 Clotting System Non Maturing Fistula Steal Syndrome
 Difficult Cannulation Pain Swollen Extremity
 Follow Up Prolonged Bleeding Low AF/ Transonic Monitoring
 OTHER: _____

CATHETER

TYPE OF CATHETER: Hemodialysis Peritoneal WHEN WAS THE ACCESS PLACED? _____

SITE/LOCATION: Tunneled Non-Tunneled Right Left Chest Thigh

DESIRED PROCEDURE Insertion Exchange Removal Repair
 OTHER: _____

INDICATION: Broken Catheter Infection Painful Catheter
 Clotted Catheter No Longer Required Poor Function
 Exchange Temporary Catheter for Permanent Catheter OTHER: _____

CLINICAL

IV DYE, CONTRAST, or SHELLFISH ALLERGY? YES NO REACTION? _____

DIABETIC? YES NO

ANY ANTICOAGULANTS? ASA COUMADIN PLAVIX OTHER _____

COMPETENT TO SIGN? YES NO, BY WHOM? _____ PHONE _____

DOES PATIENT HAVE VA INSURANCE? YES NO

TRANSPORT

DOES PATIENT REQUIRE A HOYER LIFT? _____

HOW DOES PATIENT TRANSPORT TO DIALYSIS? _____

WHO WILL TRANSPORT PATIENT TO CVA? CVA OTHER: _____

AMBULATORY CANE WALKER WHEELCHAIR STRETCHER (CVA is unable to transport)

PLEASE BE SURE TO COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM TO ENSURE PROMPT SCHEDULING.