

Carolina Vascular Access Referral Form

2214 Nelson Highway • Chapel Hill, NC 27517

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

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: _____

DIALYSIS CENTER

PHONE NUMBER

FAX NUMBER

M Tu W Th

F Sa Daily

1 2 3 4

Home Hemo

Nocturnal

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: <input type="checkbox"/> Graft <input type="checkbox"/> Fistula	WHEN WAS THE ACCESS PLACED? _____
	SITE/LOCATION: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Forearm <input type="checkbox"/> Upperarm <input type="checkbox"/> Thigh <input type="checkbox"/> HERO Graft	
	DESIRED PROCEDURE: <input type="checkbox"/> Declot <input type="checkbox"/> Fistulogram <input type="checkbox"/> Graftogram <input type="checkbox"/> Venagram <input type="checkbox"/> Vessel Mapping <input type="checkbox"/> Ultrasound <input type="checkbox"/> OTHER: _____	
	If coming for maturity evaluation or is a new access, we MUST know the date the access was placed and surgeon!	
INDICATIONS: <input type="checkbox"/> Aneurysm <input type="checkbox"/> Clotted Access <input type="checkbox"/> Clotting System <input type="checkbox"/> Difficult Cannulation <input type="checkbox"/> Follow Up <input type="checkbox"/> OTHER: _____	<input type="checkbox"/> High VP <input type="checkbox"/> Low Arterial Pressure <input type="checkbox"/> Infiltration <input type="checkbox"/> Non Maturing Fistula <input type="checkbox"/> Pain <input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Pulling Clots <input type="checkbox"/> Recirculation <input type="checkbox"/> Steal Syndrome <input type="checkbox"/> Swollen Extremity <input type="checkbox"/> Low Access Flows

CATHETER	TYPE OF CATHETER: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal	WHEN WAS THE ACCESS PLACED? _____
	SITE/LOCATION: <input type="checkbox"/> Tunneled <input type="checkbox"/> Non-Tunneled <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Chest <input type="checkbox"/> Thigh	
	DESIRED PROCEDURE: <input type="checkbox"/> Insertion <input type="checkbox"/> Exchange <input type="checkbox"/> Removal <input type="checkbox"/> Repair <input type="checkbox"/> OTHER: _____	
	INDICATION: <input type="checkbox"/> Broken Catheter <input type="checkbox"/> Clotted Catheter <input type="checkbox"/> Exchange Temporary Catheter for Permanent Catheter <input type="checkbox"/> Infection <input type="checkbox"/> No Longer Required <input type="checkbox"/> Painful Catheter <input type="checkbox"/> Poor Function <input type="checkbox"/> OTHER: _____	

CLINICAL	IODINE ALLERGY? <input type="checkbox"/> YES <input type="checkbox"/> NO	REACTION? _____
	CONTRAST/ SHELLFISH ALLERGY? <input type="checkbox"/> YES <input type="checkbox"/> NO	REACTION? _____
	HISTORY OF BED BUGS? <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST ACTIVE? _____
	HAS PATIENT RECEIVED ALLERGY RX PRE-PROCEDURE INSTRUCTIONS? <input type="checkbox"/> YES <input type="checkbox"/> NO, BY WHOM? _____	PHONE _____

TRANSPORT	DOES PATIENT REQUIRE A HOYER LIFT? _____
	HOW DOES PATIENT TRANSPORT TO DIALYSIS? _____
	WHO WILL TRANSPORT PATIENT TO CVA? <input type="checkbox"/> CVA <input type="checkbox"/> OTHER: _____
<input type="checkbox"/> AMBULATORY <input type="checkbox"/> CANE <input type="checkbox"/> WALKER <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> STRETCHER (CVA is unable to transport)	

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