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.

_____ DIALYSIS CENTER

_____ PHONE NUMBER

_____ FAX NUMBER

☐ M ☐ Tu ☐ W ☐ Th

☐ F ☐ Sa ☐ Daily

1 2 3 4

Home Hemo

Nocturnal

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 MA
• 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 Arterial Pressure	☐ Pulling Clots
☐ Clotted Access	☐ Infiltration	☐ Recirculation
☐ Clotting System	☐ Non Maturing Fistula	☐ Steal Syndrome
☐ Difficult Cannulation	☐ Pain	☐ Swollen Extremity
☐ Follow Up	☐ Prolonged Bleeding	☐ Low Access Flows
☐ 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

IODINE ALLERGY? ☐ YES ☐ NO REACTION? _____

CONTRAST/SHELLFISH ALLERGY? ☐ YES ☐ NO REACTION? _____

HISTORY OF BED BUGS? ☐ YES ☐ NO LAST ACTIVE? _____

HAS PATIENT RECEIVED ALLERGY RX PRE-PROCEDURE INSTRUCTIONS? ☐ YES ☐ NO, BY WHOM? _____ PHONE _____

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.