National Surgical Centers
STOCKTON

Access Referral Form

Date_____DOB: _____

Patient Name: _____ Weight: _____

Phone #:_____

Dialysis Days: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Dialysis Time: _____ Last dialysis Treatment Date: _____

Dialysis Facility: _____

Access Type: ☐ Right ☐ Left ☐ Graft ☐ Fistula ☐ Catheter ☐ Permanent Catheter

☐ Arm ☐ Thigh ☐ Chest

Access Problem: ☐ Clotted ☐ Poor Flows ☐ Infection ☐ Increase Venous Pressure

☐ KT/V<1.4 or URR <60 ☐ Cannulation difficulty

Referral Indication: At least 1 item **MUST** be checked

- ☐ Elevated Venous Pressure >200mmHg on a 200cc/min pump
- ☐ Elevated recirculation time of 12% or greater
- ☐ Low Urea Reduction Rate (URR) <60%
- ☐ An access with a palpable highly pulsatile thrill or "water hammer" pulse on exam (indicates outflow stenosis)
- ☐ pseudoaneurysm
- ☐ Prolonged bleeding

Explanation:

_____

_____

_____

Urgency: ☐ Hyperkalemia ☐ Fluid overload ☐ Other (explain) (call office with any urgent needs)

_____

_____

Nephrologist: _____

RN Name/Signature: _____

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