|  |  |  |
| --- | --- | --- |
| Add Health Authority Logo |  | Add Addressograph/Label |
| Add Name & Address of Vascular Access Clinic |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ATTENTION: VASCULAR ACCESS NURSE** |  |
|  |
| **REFERRAL TO VASCULAR ACCESS CLINIC** |
| **Please include: List of allergies (or copy of caution sheet), current medications, results of current blood work, current access flow measurement log, vascular access history, 3 most recent run sheets & MOST status (Medical Orders for Scope of Treatment).** |
| **Patient’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Centre Referred From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Date of referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Renal Area Referred From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Responsible Nephrologist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | [ ]  KCC Clinic | [ ]  Transplant Clinic |
| **Interpreter required:** |  |  | [ ]  Nephrologist’s Office | [ ]  HD In-Centre Unit |
| [ ]  No | [ ]  Yes | [ ]  PD Clinic | [ ]  Community Unit |
|  | If required, language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Hemodialysis Schedule:** | **[ ]  Mon** | **[ ]  Tues** | **[ ]  Wed** | **[ ]  Thurs** | **[ ]  Fri** | **[ ]  Sat** | **[ ]  Sun** |
| **Hemodialysis Time:** |  |  |  |  |  |  |  |

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| **Cause of Renal Failure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Known Antibiotic Resistant Organisms:** | [ ]  MRSA | [ ]  VRE | **Infection Status**: | [ ] Hepatitis B | [ ]  Hepatitis C |

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| **Current Access**: |  Left | Right |  |  |  | **Assessment for:**  |
| **Side:** |  |  [ ]  |  [ ]  |  |  |  | [ ] Aneurysm | [ ] Limb/Face Swelling |
|  |  |  |  |  |  |  | [ ] Clotted | [ ] Low Access Flow |
| **Location:** |  | Fistula | Graft |  |  |  | [ ] Difficulty Needling | [ ] Pain |
|  | Upper Arm |  [ ]  |  [ ]  |  |  |  | [ ] Excessive Bleeding | [ ] Poor Art Flow |
|  | Lower Arm |  [ ]  |  [ ]  | Perm | Temp |  | [ ] High CO Failure |  [ ] Steal Syndrome |
|  | Thigh |  [ ]  |  [ ]  | Cath | Cath |  | [ ] High Ven Press  | [ ] Ultrasound mapping |
|  | Int Jugular |  |  |  [ ]  |  [ ]  |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Subclavian |  |  |  [ ]  |  [ ]  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Femoral |  |  |  [ ]  |  [ ]  |  |

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| **Reason for Referral:** |  |  |  |
| **[ ]**  | Fistula Creation | [ ]  | Graft Creation |  | [ ]  Catheter Placement | [ ]  Cuffed |
| [ ]  Non-cuffed |
| **[ ]**  | Fistula Revision | [ ]  | Graft Revision |  | [ ]  Peritoneal Catheter | [ ]  Insertion |
| [ ]  Routine Assessment |

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| **Problem Access Creation Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Other relevant information** (please specify): **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |