|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |

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