TMA Vascular Access Center

1597 Washington Pike, Unit A-14
Bridgeville, PA 15017
412-276-9030 PH
412-276-9033 FAX

Referral Form

Today's Date _______________

Patient Name ____

Address below is: ☐ Patient's Actual Home ☐ Patient's Nursing Home *(select patient's physical address)*

Street Address ____

City ________________________________ **State** ______________ **Zip Code** _______________

Telephone (*Patient/Nursing Home*) __________________ **Last Dialysis Treatment** ________________

Access Type: ◯ AV Graft / ◯ AV Fistula **Surgeon & Date of Creation** ________________________

Location: ☐ Right ☐ Left ☐ Forearm ☐ Upper Arm ☐ Chest ☐ Thigh

Desired Procedure: ☐ Declot ☐ Fistulogram/Graftogram ☐ Venogram ☐ Other ______________

INDICATION

☐ Clotted Access ☐ Steal Syndrome ☐ Maturing Evaluation
☐ Infiltration ☐ High Venous Pressures ☐ Decrease of Access Flow
☐ Prolonged Bleeding ☐ Difficult Cannulation ☐ Need for Peripheral Access
☐ Decreased KT/V ☐ Swollen Extremity ☐ Aneurysm
☐ Hyperpulsatile ☐ Pain ☐ High Pitched Sounds on AVF
☐ Recurrent Stenosis ☐ Decreased URR

Last 2 Access Flows with dates: __________ & _________ **BFR**______ **AP** -_____ **VP**______ **Needle**____

Catheter Procedure

Site: ☐ Tunneled ☐ Non-Tunneled ☐ Right ☐ Left ☐ Chest ☐ Groin

Date of Insertion: _____________ **Surgeon/Interventional Radiologist**_________________

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal

INDICATION

☐ Clotted Catheter ☐ Poor Function ☐ Infection
☐ Broken Catheter ☐ No Longer Required ☐ Other ________________
☐ Exchange Temporary Catheter to Permanent Catheter

Clinical Information

X-Ray Contrast Allergy? .... ☐ Yes ☐ No If YES, Reaction? ___________________________

Diabetic? .... ☐ Yes ☐ No

Coumadin/Eliquis/Other Lytics? ☐ Yes ☐ No If YES, medication? ___________________________

Competent to Sign Consent? ..... ☐ Yes ☐ No If NO, Whom? ___________ Phone _____________

History of MRSA/MDRO/C-DIFF? ☐ Yes ☐ No If YES, when? ___________________________

Covid-19 Vaccination Type/Dates____

Medication Allergies ____

Dialysis Center ___________________________ Phone _________________ Fax ____________________

Referring MD _________________________ Form completed by____________________

Post-Procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other _____________________

Fax the following:

☐ **Facesheet/ Insurance Info**
☐ **Co-Morbids, Lab Results and Med list**

Dialysis Schedule:

No treatment in last 5 days? STAT K+

M/W/F	**T/Th/Sat**
1 2 3	**1 2 3**

If the patient is on Coumadin: STAT INR the day prior to procedure