RMAVASI004

RMA Vascular Access Center

3821 Masthead St. NE
Albuquerque, NM 87109
Phone: 505-998-7461
Fax: 505-314-0795

HD days (Circle one)
M W F
T T S

Date: _____ Referring Provider: _____ Referring Center & Tel#: _____

Patient Name: _____ DOB: _____ Sex: M / F HD Shift: 1 2 3 4 Home

Residence: Dialysis Clinic/Unit: _____

☐ Private Home Phone# _____

☐ Skilled Nursing Facility (SNF) _____ Phone # _____

☐ Other _____ Phone # _____

**Activated POA/HCP: Name and Tel # _____

Transportation: ☐ YES ☐ NO ☐ NEED SUPPORT (Commute, wheelchair, walker, stretcher/Bed bound etc.)

INDICATIONS

DIALYSIS ACCESS

- ☐ Aneurysm
- ☐ Clotted access
- ☐ Difficult cannulation
- ☐ High Arterial pressures
- ☐ High flow Fistula
- ☐ High Venous pressures
- ☐ Low flow/clearance
- ☐ Prolonged bleeding
- ☐ Infection/Drainage
- ☐ Renal Recovery
- ☐ Access evaluation
- ☐ Swollen extremity
- ☐ Central stenosis
- ☐ Catheter Malfunction/Damage
- ☐ CKD V need to initiate dialysis
- ☐ Non maturing Fistula
- ☐ Infiltration
- ☐ Pain or numbness in extremity
- ☐ Acute Kidney Injury requiring dialysis

Access: ☐ AVF ☐ AVG ☐ CATHETER

Location: ☐ Right ☐ Left _____ *(please indicate anatomical site)*

VASCULAR

- ☐ Varicose/spider veins
- ☐ Lower extremity swelling
- ☐ Lower extremity ulcers
- ☐ Chronic venous insufficiency
- ☐ Deep Vein Thrombosis

IV Therapy

- ☐ Long-term antibiotics/Infusions
- ☐ Chemo

Tunneled Central line- (Circle one)
PICC or HICKMAN
Single or Double LUMEN

GENERAL

- ☐ Wound/Decubiti
- ☐ Mass/Growth
- ☐ Abscess
- ☐ Injury/foreign body
- ☐ Burn (1st or 2nd deg)
- ☐ Hand

PROCEDURES/STUDY

- ☐ Fistulagram/Graftogram
- ☐ Declot
- ☐ Banding of fistula
- ☐ Coil embolization/Ligation of veins
- ☐ Fistula ligation
- ☐ Arteriovenous fistula creation
- ☐ Balloon assisted maturation (BAM)
- ☐ Other _____
- ☐ HD Tunneled Catheter insertion
- ☐ HD Tunneled Catheter exchange
- ☐ HD Tunneled Catheter removal
- ☐ Tunneled Central line insertion
- ☐ Tunneled Central line exchange
- ☐ Tunneled Central line removal
- ☐ Chemo-port creation
- ☐ Ultrasound evaluation
- ☐ PD Catheter insertion
- ☐ PD Catheter exchange
- ☐ PD Catheter removal
- ☐ Perito-neogram
- ☐ PD catheter revision
- ☐ PD catheter-Embedded
- ☐ Wound debridement
- ☐ Incision & Drainage
- ☐ Wound care
- ☐ Foreign body removal
- ☐ Evaluate and Treat
- ☐ Mass excision
- ☐ Laceration repair
- ☐ Tissue Biopsy *(superficial)*

Comments: _____

_____

Please fax the following information as appropriate: *if dialysis patient, treatment sheet sufficient with referral form.*

☐ Referral Form ☐ H&P *(Within 30 days)* ☐ Demographics ☐ Medication list *(current)*

Nurse name and Signature: _____ Date: _____

Provider Signature: _____ Date: _____