

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

HD days (Circle one)

Referring Center &

M W F

Date: _____ Referring Provider: _____ Tel#: _____

T T S

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

- Access evaluation
- Clotted access
- Difficult Cannulation
- High Arterial pressures
- High Venous pressures
- Poor flow/clearance
- Prolonged bleeding
- Renal Recovery
- Aneurysm
- Catheter Malfunction/Damage
- CKD IV/V
- Infection/Drainage
- Infiltration
- Pain or numbness
- Swollen extremity
- Plasmapheresis

VASCULAR

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

GENERAL

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

IV Therapy

Long-term antibiotics/Infusions

Therapy completion

Chemo

Tunneled Central line - PICC or HICKMAN

Access: AVF AVG CATHETER

Location: RIGHT LEFT _____ (please indicate anatomical site) Single or Double LUMEN

PROCEDURES/STUDY

- Chemo-port creation
- Declot
- Fistulagram/Graftogram
- Fistula ligation
- HD Catheter insertion
- HD Catheter removal
- HD Catheter exchange
- PD Catheter insertion
- PD Catheter exchange
- PD Catheter revision
- PD Catheter removal
- PD Catheter-Embed
- Tunneled Central line insertion
- Tunneled Central line exchange
- Tunneled Central line removal
- Other
- Evaluate and Treat
- Foreign body removal
- Incision & Drainage
- Laceration repair
- Mass excision
- Ultrasound evaluation
- 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: _____