DIALYSIS ACCESS PATIENT REFERRAL FORM

USA UNIVERSITY SURGICAL ASSOCIATES
Exceptional surgeons. Compassionate care.

ACCESS REFERRALS ONLY -- PLEASE USE USA PATIENT REFERRAL FORM FOR ALL OTHER REFERRALS

USA DIALYSIS ACCESS SURGEONS

Michael Barfield, MD
Ehsan Benrashid, MD
Michael Greer, MD
Charles Joels, MD
Neelima Katragunta, MD

Date: _____

Reason for Referral: (check all that apply)

☐ Initial vascular referral
☐ Prolonged bleeding
☐ Difficult cannulation
☐ Multiple sticks
☐ Inadequate flow
☐ Clot aspiration
☐ Pain
☐ Swelling
☐ Elevated venous pressure
☐ Abnormal labs: VRR/Kt/V/urea

Explain Details: _____
_____

Request for:

☐ Office visit
☐ Fistulagram
☐ Ultrasound
☐ Other: _____

Is this request ☐ emergent or ☐ first available within two weeks

USA Surgeon Requested: _____ or ☐ 1st available

Patient Name: _____

Address: _____City, State, Zip_____

Home Phone: _____ Cell:_____ Other: _____

Date of Birth: _____ Select: ☐ Male ☐ Female **Attach Face Sheet**

Relevant Medical History

Current Access: ☐ none ☐ catheter ☐ fistula ☐ graft

Previous Accesses: ☐ AVF ☐ AVG ☐ Perm Cath

Access Location: _____ Date Placed: _____ Surgeon:_____

Is patient on dialysis? ☐ Yes ☐ No If 'Yes" what days? ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ S ☐ Su

Dialysis Clinic: _____ Start time: _____

Does patient require public transportation? ☐ Yes ☐ No If yes, # of days notice needed: _____

Is patient currently in a skilled nursing facility? ☐ Yes ☐ No

Nephrologist/Referring Physician: _____

Practice: _____ Office Contact: _____

Email: _____ Phone: _____ Fax: _____

Along with this form, please send: Vein Mapping Order, Relevant H&P, Office Notes

FAX TO: 423-493-2368 or

EMAIL: USAVascAccess@universitysurgical.com

Thank you for your referral! USA will contact you with the following appointment information:
Appointment Date and Time, USA Physician, and USA Office