fraserhealth

VASCULAR CLINIC REFERRAL
ATTENTION: VASCULAR ACCESS COORDINATOR

MSXX102158C Rev: May 19/11 Page: 1 of 1

Fraser Health Vascular Access Clinic
Jim Pattison Outpatient Care and Surgery Centre - 3rd Floor
9750 140th Street Surrey, B.C. V3T OG9

Phone: (604) 587-7640 **Fax: (604) 587-7670**

Date of Referral: _____

Responsible Nephrologist: _____

Patient's Full Legal Name: _____ (Last) _____ (First) _____ (Middle)

Other Name(s) (if applicable): _____

Personal Health Number: _____ **Date of Birth:** ___/___/___ (DD,, MM, YYYY) **Gender: M** ☐ **F** ☐

Address: _____ (Street) _____ (City) _____ (Postal Code)

Home Phone No. _____ ☐ Okay to Call **Message Phone No.** _____

Insurance Type ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces #: _____

Renal Area Referred From: _____

☐ CKD Clinic ☐ PD Clinic ☐ HD In-Centre Unit ☐ Community Unit
☐ Nephrologist's Office ☐ Transplant Clinic Other: _____

Reason for Referral:

☐ AVF/AVG Creation ☐ AVF/AVG Revision ☐ Assessment

******Note- For Perm Cath booking: Contact Surgeon Office Direct ******

Assessment for:

☐ Aneurysm ☐ High CO Failure ☐ Low Access Flow ☐ Steal Syndrome
☐ Clotted ☐ High Venous Pressure ☐ Pain ☐ Other _____
☐ Excessive Bleeding ☐ Limb/Face swelling ☐ Poor Arterial Flow _____

Current Access:	**Fistula**	**Graft**	**Catheter**
Side:	☐ Upper Arm	☐ Upper Arm	☐ Internal Jugular
☐ Left ☐ Right	☐ Lower Arm	☐ Lower Arm	☐ Suclavian
		☐ Thigh	☐ Femoral

Hemodialysis Schedule:	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Hemodialysis Time:							

Known ARO Precautions: ☐ MRSA ☐ VRE **Infection Status:** ☐ Hepatitis B ☐ Hepatitis C

Problem Access Creation Date: _____ Hospital: _____

Other relevant information (please specify): _____

Signature: _____ Date: _____

Please Include:
☐ Allergies (reactions)
☐ Current medications
☐ Patient history
☐ Three dialysis run sheets

Appointment Date/Time:
Date: _____
Time: _____
Doctor:

☐ For Creations: Fax to Mirita 604-587-7670
☐ Faxed to Vascular Booking 604 582-3787
☐ For follow up phone Vascular Booking for Appointment at 604 582-4563
☐ Notified Patient of time & date
***Please note- Clinic days are Tuesday**
☐ Faxed to Source

Family Physician (if different from referring source)
Name _____
MSP #. _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

Referring Health Care Provider:
Name _____
MSP #. _____
Phone: _____ Fax: _____
☐ GP ☐ Specialist ☐ NP ☐ Hospitalist ☐ ER