



fraserhealth

VASCULAR CLINIC REFERRAL

ATTENTION: VASCULAR ACCESS COORDINATOR



MSXX102158C

Rev: May 19/11

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Fraser Health Vascular Access Clinic
Jim Pattison Outpatient Care and Surgery Centre - 3rd Floor
9750 140th Street Surrey, B.C. V3T 0G9

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:** ____/____/____ **Gender: M F**
(DD., MM, YYYY)

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: Side: <input type="checkbox"/> Left <input type="checkbox"/> Right	Fistula <input type="checkbox"/> Upper Arm <input type="checkbox"/> Lower Arm	Graft <input type="checkbox"/> Upper Arm <input type="checkbox"/> Lower Arm <input type="checkbox"/> Thigh	Catheter <input type="checkbox"/> Internal Jugular <input type="checkbox"/> Suclavian <input type="checkbox"/> Femoral
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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: <input type="checkbox"/> Allergies (reactions) <input type="checkbox"/> Current medications <input type="checkbox"/> Patient history <input type="checkbox"/> Three dialysis run sheets	Appointment Date/Time: Date: _____ Time: _____ Doctor: _____
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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: _____ <input type="checkbox"/> Patient has no GP/NP	Referring Health Care Provider: Name _____ MSP #. _____ Phone: _____ Fax: _____ <input type="checkbox"/> GP <input type="checkbox"/> Specialist <input type="checkbox"/> NP <input type="checkbox"/> Hospitalist <input type="checkbox"/> ER
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