

VASCULAR CENTER OF WICHITA NEPHROLOGY
2630 NORTH WEBB ROAD, SUITE 200
WICHITA, KS 67226
PHONE 316-636-1234 • FAX 316-636-2630

REFERRAL SHEET

PATIENT NAME _____ DOB _____ SS# _____

ADDRESS _____

TELEPHONE NUMBER (H) _____ (W) _____

DIALYSIS UNIT _____ DIALYSIS SCHEDULE _____

ATTENDING NEPHROLOGIST _____ REFERRING NEPHROLOGIST _____

VASCULAR SURGEON _____

PROBLEM: _____ **CLOTTED** _____ LOCATION _____

_____ GRAFT

_____ FISTULA

_____ **FISTULAGRAM WITH POSSIBLE ANGIOPLASTY** LOCATION _____

_____ GRAFT

_____ FISTULA

_____ HIGH VENOUS PRESSURE _____ ABNORMAL ARTERIAL PRESSURE _____ POOR BFR

_____ PROLONGED BLEEDING _____ ABNORMAL TRANSONIC® _____ OTHER*

IF "OTHER" PLEASE SPECIFY _____

_____ **CATHETER**

_____ POOR FLOW _____ INFECTED _____ FRACTURED

ACCESS DATE OF CREATION _____

ACCESS DATE OF REVISION _____