

**Physician Order/Referral Form
Dialysis Access Center of Tyler**

Name: _____ DOB: _____

Phone: _____ Dialysis Center: _____

Access Type: _____ Access Location: _____

Reason for Referral

Clotted	Decreased Transonic® Flow % dropped _____ Flow rate _____
Kt/V<1/4/Decreased URR	Mature Perm Access
Increased Bleeding	Check Maturity
Removal Due to Infection	Increased Art/Vein Pressure
Difficult Cannulation	Other _____

Procedure Requested

Decлот	Venogram
Angio	Tunnel Catheter Place
Temp Cath Place	Catheter Exchange
Removal of Tunnel Catheter	Other _____

Date and Time of Appointment: _____

Comments: _____

Print Nurse's Name: _____

Verbal order _____ Telephone order _____ Physician name _____