Request For Dialysis Access Services

Fax: (801)262-1533 Scheduling: (801)281-0027
650 East 4500 South Suite 100, Salt Lake City, Utah 84107

Patient Name:_________________________________ DOB:_______________

Patient's Phone:_________________ Insurance Carrier:_____________________

Referring Provider:______________________Dialysis Center: ________________

Provider Phone:____________________Provider Fax:_______________________

Dialysis Center Contact (Name, phone, fax):____________________________________

Diagnosis/Symptoms:____

○ Dialysis Graft/Fistula De-clot ○ Problematic (not thombosed) Fistula

○ Remove Dialysis Catheter ○ Replace/Repair Problematic Dialysis Catheter

○ Hemodialysis Catheter Placement ____ Acute ____ Chronic

○ Other

Is the patient on blood thinners? Y / N Is patient Allergic to contrast? Y/N

Check if one applies: Coumadin___ Heparin____ Plavix___ Aspirin ____ Other______

Comments:

History (*If Known. Helpful, Not Necessary):*

1. Graft or Fistula? _________________
2. Type of Fistula/Graft and location: ____
3. When was CVC/Fistula/Graft placed? _______________ How long has it been used?________
4. Any prior thrombosis or de-clot? _________________
5. Physician who placed access:____

PROVIDER SIGNATURE:______________________________________ **Date:**_____________