Please complete this form electronically or by hand and e-mail it to bodyaccess@smh.ca -or- fax it to (416) 864-5609.

DIALYSIS BODY ACCESS REFERRAL FORM

St. Michael's
Inspired Care. Inspiring Science.

Once completed please send to:
Email: BodyAccess@smh.ca
Fax: 416-864-5609

Click Here to Print Form

Date of referral (dd/mm/yy): _____

Referring facility: _____
Referring physician: _____
Tel.: ( ) _____ Fax: ( ) _____
Request for: ☐ Consult only ☐ Consult and surgery

Patient Information:

Name: _____ Date of birth (dd/mm/yy): _____
OHIP #: _____ Version code: _____ Expiry (dd/mm/yy): _____
Street Address: _____ City/Town: _____
Home Tel.: ( ) _____ Other Tel.: ( ) _____
Sex: _____ Weight: _____ **kg** Height: _____ **cm**

Primary cause of renal failure: _____
Allergies: _____ Isolation precautions: _____
Present patient status: ☐ CKD ☐ PD pt. ☐ In-centre hemodialysis pt. ☐ Home hemodialysis pt. ☐ Transplant pt.

For New Accesses:

☐ New fistula ☐ New graft ☐ New PD catheter ☐ Embedded ☐ Non-embedded
Reason for access creation/insertion: ☐ Expected dialysis start <6 months ☐ Expected dialysis start >6 months ☐ Other reason: _____

For Existing Hemodialysis Accesses:

☐ Existing fistula ☐ Existing graft ☐ Existing CVC ☐ Limbs are reversed
Reason for revision: ☐ Rapidly failing access and/or inadequate dialysis ☐ Maturation failure requiring revision ☐ Other reason: _____

☐ Pt. expected to self cannulate Pt.'s dominant hand: ☐ Right ☐ Left

For Existing PD Catheters:

Reason for revision: ☐ Non-functioning catheter that needs to be revised or replaced ☐ Removal of PD catheter

The following information MUST be sent along with this referral form:

1) Current medical history and medication list
2) Access history (ie. PICC lines, CVCs, infections, AVF/AVG & complications) - include side & number
3) Any vascular mapping and/or interventional radiology reports (include any CDs)
4) Most recent blood work (must include CBC, lytes, BUN, Crt. HbAg, HbAb, & INR)
5) Most recent echocardiogram report if available
6) Discharge summaries if patient was admitted within the past 6 months
7) Any special needs such as an interpreter, transporation assistance etc.

Signature of referring physician: _____

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