



920 NE 13th Street | Oklahoma City, OK 73104
Phone (405) 271-7498 | Fax (405) 271-1772

Dialysis Access Referral - Adult & Pediatric

Are you referring this patient for a Kidney Transplant Evaluation? ☐ YES ☐ NO

DATE: _____

This is a Non-English speaking patient: ☐ YES ☐ NO

Patient Name: _____ SSN: _____ Age/DOB: _____

Male/Female: _____ Race: _____

Current Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Phone #'s: Home: _____ Cell: _____

Previous Transplant: ☐ YES ☐ NO Date: _____

Dialysis Days: M W F
T Th Sat

What type of access is requested?

PD Catheter

AVF & PD Catheter

Revision of Existing Access (specify)

AV Fistula

AV Graft

Insurance:

☐ Medicare

☐ Medicaid

☐ No Insurance/Private Pay

☐ Commercial Insurance: _____

(i.e. BC/BS, CIGNA, Aetna)

Please send the following information with the referral form:

☐ Recent H&P or Office Note

☐ Insurance Information

☐ Medication List

☐ Demographic Sheet

REFERRING PHYSICIAN:

NPI: _____

Printed Name _____

Mailing address _____

City _____

State _____

Zip _____

Phone: _____

Fax: _____