

**Michael E. DeBakey  
Department of Surgery**

**Division of Vascular Surgery  
and Endovascular Therapy**



**GIVING LIFE TO POSSIBLE.**

**DIALYSIS ACCESS REFERRAL FORM**

Date: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Referring Physician: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_

Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**REASON FOR REFERRAL**

- Fistula/Graft Creation
- Fistula/ Graft Problem: \_\_\_\_\_

**DIALYSIS INFORMATION**

Is the patient on dialysis? Yes No First date of dialysis: \_\_\_\_\_

Method (circle one): AV Fistula/Graft or HD catheter or PD catheter

Dialysis Center: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Dialysis Days (circle one): Mon/Wed/Fri or Tues/Thurs/Sat

**This form may be submitted by:**

Email: [surgerysched@bcm.edu](mailto:surgerysched@bcm.edu)

or

Fax: 713-798-8131

Healthcare Professionals: If you have any questions, please contact: 713-798-7840.

Thank you for choosing Baylor College of Medicine Division of Vascular Surgery and Endovascular Therapy.

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