



University of Kentucky Vascular Access Service Vascular Access Consultation Form

Referral Instructions: To refer a patient to the University of Kentucky Vascular Access Service, please fax this form and your cover sheet to 859-257-3644. To speak with a representative directly, call 859-323-2766. We appreciate your referral and look forward to working with you and your patients.

If available, please provide the following items with this fax:

- Patient demographic sheet
- Medication list
- Copy of insurance cards (front and back)
- Recent history and physical and/or discharge summaries

Patient Information

Last name	First name	Middle initial	Date of birth (month/day/year)
Mailing address			Social Security number
City	State	Zip	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Maiden name	Mother's maiden name		(____) _____ Phone number
Interpreter needed? <input type="checkbox"/> Y <input type="checkbox"/> N Height _____ Weight _____			

Dialysis Unit Information

Dialysis unit	Contact name	(____) _____ Phone number
Address		(____) _____ Fax number
City	State	Zip code County
On what day(s) of the week does the patient have dialysis? <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Other		

Referring Physician Information

Physician name	Contact name	(____) _____ Phone number
Physician NPI number		Email
Address		(____) _____ Fax number
City	State	Zip code County

Thank you for consulting with the University of Kentucky Vascular Access Service.