**New Patient Vascular Access Referral Letter**

Name ..................................... Hospital Number ..................................

DOB .....................................

Dialysis Status Pre-Dialysis Hospital HD CAPD

Has the patient had Covid in the last 7 weeks? Date ..................................

If pre-dialysis, expected dialysis start date ....................................................................................

Previous Fistula Yes No

If yes, please specify .......................................................................................................................

Previous Temporary Vascular Access Yes No

If yes, please include all (L) I.J

 (R) I.J

 (L) S.C

 (R) S.C

 (L) Tunnelled Line

 (R) Tunnelled Line

Current Vascular Access Yes No

If yes, please specify and include details of any problems ............................................................

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Days on Dialysis **M,W,F T,TH,S**

 AM PM EVE AM PM EVE

Previous Relevant Medical History ................................................................................................

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Anticoagulation Therapy None

 Aspirin/Clopidogrel (or Antiplatelet)

 Warfarin

 Other, please specify .................................................................

Please Complete **MRSA VRE Clostridium MDR**

Urgency **Routine Soon Urgent**

**Funtioning** Fistula Required ASAP (within 3 months)

 Within 6 months

Suitable for Day Case Yes No

Suitable for Local Anaesthetic Yes No

Referring Physician ........................................................ Date .............................

**Please email to RenalVascularAccessNurses@nhslothian.scot.nhs.uk**