LIFEBRIDGE HEALTH

LifeBridge Health Dialysis Access Placement Referral Form

Date of Referral: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

Emergency Contact: _____ Emergency Contact #: _____

Diagnosis Code: _____

Evaluation for New Access:

☐ Arteriovenous Fistula ☐ Arteriovenous Graft ☐ Peritoneal Dialysis Catheter

☐ Cardiology Clearance for Surgery ☐ Electrocardiogram

☐ Ultrasound Venous Mapping (check one): ☐ Bilateral ☐ Left ☐ Right
☐ Lower Extremity ☐ Upper Extremity

Referring Nephrologist/Provider:

Provider: _____ Contact Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Dialysis Center:

Name: _____ Contact Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Type: ☐ Hemodialysis ☐ Peritoneal Dialysis

Schedule: ☐ M/W/F ☐ Tu/Th/Sa

Please send completed forms to ESRD Navigator at ESRDNavigation@lifebridgehealth.org or fax to 410-601-9597.

For any questions, please contact 410-601-1049.

CARE BRAVELY