TRANSPLANT

Dialysis Access Referral

940 NE 13th Street ♦ Suite 1000 ♦ Oklahoma City, OK 73104

University of Oklahoma Transplant
Contact: Yaritza Rivera (405) 271-7498
FAX (405) 271-1772

Patient Name: _____

DOB: ___ /____ /_____ **Patient phone #** ( ) _____

What type of access is requested?

_____ **PD Catheter**
_____ **AV Fistula**
_____ **AV Graft**
_____ **Revision of existing access (specify)**
_____ **AVF and PD Catheter**

Patient's Dialysis Days: **M W F** _____
T T S _____

Please attach the following:

- ☐ Recent H&P or office note
- ☐ Medication list
- ☐ Insurance information
- ☐ Demographic Sheet

Who can we contact in your facility for more information?

Name:_____

Phone Number: ( ) _____