Mercy
TRANSPLANT CENTER
A service of Mercy Medical Center–Des Moines

DIALYSIS ACCESS REFERRAL FORM

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Phone: 515-643-8770 Fax: 515-643-8808

DATE OF REFERRAL: _____

TYPE OF ACCESS EVALUATION REQUESTED (please check):
❑Peritoneal Dialysis Catheter ❑AV Fistula ❑Other: _____

Patient Name (please print): _____

Patient Date of Birth: _____ Patient Social Security #: _____

Patient Address: _____

Patient Telephone #: _____ Alternate #: _____

Does the patient speak English: ❑Yes ❑No - If no, what language? _____

Referring Physician: _____

Referring Physician Telephone #: _____ Fax: _____

Referring Dialysis Unit: _____

Does the patient currently have dialysis access? ❑Yes – what type? _____
❑No

Primary Insurance: _____ ID# _____
Secondary Insurance: _____ ID# _____

Please fax the following information to the transplant center with this completed form:

1) Demographic Information
2) Insurance Cards (front and back)
3) Most recent history and physical
4) Dialysis plan of care
5) 2728 form
6) Current medication list
7) Vaccination history

Reviewed: 10/08/2018
Revised: 10/08/2018