

**Medical Referral Form
For NKF Paediatric Vascular Access Subsidy**

Form A

A. Personal Information of Patient:

Name: _____

IC No.: _____ Tel. No. _____

Dialysis Centre/Hospital: _____

Parent/Guardian: _____ Tel No: _____

B. Referral for Vascular Access Creation (Quotation Attached):**

Location: _____

Vascular Surgeon: _____ Cost: _____

C. Etiology of ESRD: _____

D. Clinical Summary/Comorbidities:

i) _____ ii) _____

iii) _____ iv) _____

E. Renal Replacement History:

E1. Dialysis Prescription (√): APD CAPD + Extraneal

Dialysis System: Baxter/Vantive FMC Luxencia

Date PD Initiated: _____

Date PD Drop Out: _____

E2. Date HD Initiated: _____

History of Previous Vascular Access (if any):

i) _____ ii) _____

iii) _____ iv) _____

F. Other Information:

Name of Nephrologist: _____

Signature: _____

MMC No.: _____

Date: _____

Hospital: _____

E-Mail: _____