Date: [Date]

To: [Recipient Physician Name]
Department: [Department Name/Vascular Surgery]
Address: [Facility Address]

RE: Referral for Hemodialysis Access Vein Mapping

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID/MRN: [ID Number]

Dear Dr. [Recipient Last Name],

I am referring this patient to your service for a formal upper extremity vein mapping and vascular surgical consultation to evaluate for permanent hemodialysis access.

Clinical Background:
The patient has Stage [Number] Chronic Kidney Disease with a current GFR of [Number] mL/min. It is anticipated that renal replacement therapy will be required within the next [Number] months.

Co-morbidities:
[List relevant conditions, e.g., Diabetes, Hypertension, Peripheral Artery Disease]

Current Access Status:
[e.g., No current access / Non-functioning fistula / Tunnelled dialysis catheter]

Requested Services:
1. Duplex ultrasound vein mapping of [Left/Right/Both] upper extremities.
2. Evaluation for the creation of an Arteriovenous (AV) Fistula or AV Graft.
3. Surgical plan for optimal access site based on vessel caliber and patency.

The patient has been instructed to avoid venipuncture and IV starts in the [Left/Right] arm to preserve the vasculature for this procedure.

Please provide a copy of the mapping results and your surgical recommendations following the consultation.

Sincerely,

[Your Name, MD/DO/NP/PA]
[Practice Name]
[Phone Number]
[Fax Number]