Dialysis Access Center Patient Scheduling Form

NOTE: **In compliance with the *Universal Protocol for Wrong Site Surgery*, all areas highlighted in BLUE must be completed in full by the referrer.**

Today's Date: _____

Patient Name: _____ **Phone No.:** _____

Patient Address: _____ **City:** _____ **State:** _____ **Zip:** _____

(If nursing home, please indicate and use that address and phone number.)

Access Procedure: ● AV Fistula ● AV Graft

Location: ☐ Right / ☐ Left ☐ Forearm ☐ Upper Arm ☐ Chest ☐ Thigh

Desired Procedure: ☐ Declot ☐ Fistulogram/Graftogram ☐ Venogram ☐ Ultrasound ☐ Vein Mapping

☐ ***Other*** _____

Indication:

☐ Clotted Access	☐ Pain	☐ Non Maturing Fistula
☐ High Venous Pressure	☐ Infiltration	☐ Access Surveillance
☐ Prolonged Bleeding	☐ Difficult Cannulation	☐ Steal Syndrome
☐ Recirculation	☐ Swollen Extremity	☐ Aneurysm

Prior Access Surgeries: _____

_____

Catheter Procedure:

Site: ☐ Tunneled / ☐ Non-Tunneled ☐ Right / ☐ Left ☐ Chest / ☐ Groin ☐ Neck

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal ☐ Repair ☐ Other _____

Indication:

☐ Clotted Catheter	☐ Painful Catheter	☐ Infection
☐ Broken Catheter	☐ No Longer Required	☐ Other _____
☐ Exchange temporary catheter for permanent catheter		

Clinical Information:

X-Ray Contrast Allergy ☐ Yes ☐ No ☐ Reaction? _____

Diabetic ☐ Yes ☐ No

Any Anticoagulants? ☐ Coumadin ☐ Plavix ☐ ASA ☐ Other _____

Competent to Sign Consent? ☐ Yes ☐ No **If No, Whom?** _____ **Phone:** _____

Transportation Needs:

Is the patient able to provide or arrange their own transportation? ☐ Yes ☐ No

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Stretcher

Post- procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other _____

Dialysis Clinic – Please complete the following information:

Referred by: _____ **Phone:** _____ **Fax:** _____

Nephrologist: _____ **Surgeon:** _____

Verbal order taken by: _____ **from** _____ ☐ **Physician** ☐ **ARNP**

If the patient is confused or forgetful, a second signature is REQUIRED: _____

Some or all of the following may be required to be faxed to our office:

1. Order *2.* Insurance Cards *3.* Pt. Demographic Sheet *4.* Medication List *5.* Most recent H&P *6.* Current Labs

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Tel: 510.251.1002 ▪ Fax: 510.251.1034

DAC Use Only – Appointment Date/Time: _____ ***Pickup Time:*** _____ ***Confirmed By:*** _____

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