Metropolitan Vascular Institute

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HD Scheduling/Order Form

Todays Date: _____ Requested procedure date: _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone No.: (Home) _____ (Cell) _____ (Work) _____

Access Procedure:

Access Type: ❑ *AV Graft* ❑ *AV Fistula* ❑ *PD Catheter* ❑ *Other*

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

Desired Procedure: ❑ Declot ❑ Fistulogram/Graftogram ❑ Venogram ❑ Vein Mapping

❑ ***Surgical Consult*** _____

❑ ***Other*** _____

Indication:

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

Access Procedure:

Access Type: ❑ Tunneled / ❑ Non-Tunneled ❑ Right / ❑ Left ❑ Chest / ❑ Groin

Desired Procedure: ❑ Insertion ❑ Catheter Change ❑ Removal ❑ Other _____

Indication:

❑ Clotted Catheter ❑ Poor Function ❑ Infection
❑ Broken Catheter ❑ No Longer Required ❑ Other _____

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:

Will Patient provide own transportation? ❑ Yes ❑ No

❑ Ambulatory ❑ Cane ❑ Walker ❑ Wheelchair ❑ Stretcher

❑ **VIV Arranged Transport:** Company _____ Phone _____ Initials _____

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

Dialysis Center: Please fill out the following information in full:

Referred by: _____ Phone _____ Fax: _____

Nephrologist: _____ Surgeon: _____

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. Insurance Cards **2.** Pt. Demographic Sheet **3.** Medication List **4.** Most Recent H&P