SJVSC South Jersey Vascular Surgery Center

DIALYSIS ACCESS APPOINTMENT REQUEST

Patient Name _____ Today's Date _____

Patient Street Address _____ Patient Phone _____

Patient City, State, Zip _____

Patient Birth Date (Month, Date, Year) _____

Patient Height _____ Patient Weight _____ Date of Last Dialysis Treatment _____

Access Type ☐ AV Graft / ☐ AV Fistula Date of Creation _____

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

Desired Procedures ☐ Declot ☐ Fistulogram / PTA / Stent ☐ Venogram ☐ Other _____

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

Catheter Procedure Date of Insertion _____

Location ☐ Right / ☐ Left ☐ Tunneled / ☐ Non-Tunneled ☐ Chest / ☐ Groin

Desired Procedures ☐ Insertion ☐ Catheter Change ☐ Removal

Indication ☐ Clotted Catheter ☐ Poor Function ☐ Infection
☐ Broken Catheter ☐ No Longer Required ☐ Other _____
☐ Exchange temporary catheter for permanent catheter

Clinical Information X-ray contrast allergy ☐ Yes ☐ No Reaction? _____

Blood Thinners _____

Competent to sign consent ☐ Yes ☐ No If no, whom _____ Phone _____

Transportation Does patient need transportation for appointment? ☐ Yes ☐ No

☐ Ambulatory ☐ Wheelchair ☐ Stretcher

Dialysis Center _____ Phone _____ Fax _____

Nephrologist _____ Surgeon _____

Referring Physician _____

FAX FORM WITH PATIENT DEMOGRAPHIC SHEET, INSURANCE CARDS, CURRENT LABS, MEDICATION, HISTORY AND PHYSICAL TO 856-482-9399 FOR SCHEDULING