

VASCULAR ACCESS DIAGRAM – FAX to Dialysis Facility and/or Nephrologist

Patient Name _____ Procedure Date _____
 Diagram Completed by Surgeon Interventional Radiologist Interventional Nephrologist
 Name (Surgeon or Interventionalist) _____ Phone (____) _____
 FAX to: Nephrologist Name _____ FAX # (____) _____
 Facility Name _____ FAX # (____) _____

Procedure(s) - Check all that apply	Access Type	Configuration	Location
SURGERY <input type="checkbox"/> New Access <input type="checkbox"/> Thrombectomy <input type="checkbox"/> Revision <input type="checkbox"/> Other- specify: _____ INTERVENTIONAL (Endovascular) <input type="checkbox"/> Thrombolysis / Thrombectomy <input type="checkbox"/> PTA <input type="checkbox"/> Stent <input type="checkbox"/> Catheter insertion or revision <input type="checkbox"/> Diagnostic Fistulogram only <input type="checkbox"/> Other- specify: _____	<input type="checkbox"/> A/V Graft <input type="checkbox"/> A/V Fistula <input type="checkbox"/> Port device <input type="checkbox"/> Central venous Catheter If new catheter, priming volume: _____ ml <input type="checkbox"/> Cuffed <input type="checkbox"/> Non-cuffed Graft Material (if applicable) <input type="checkbox"/> PTFE <input type="checkbox"/> Other – specify: _____	Graft (if applicable) <input type="checkbox"/> Loop <input type="checkbox"/> Straight <input type="checkbox"/> Curved Fistula Construction (if applicable) <input type="checkbox"/> Radio-cephalic <input type="checkbox"/> Brachio-cephalic <input type="checkbox"/> Transposed Type: _____ <input type="checkbox"/> Other – specify: _____	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Forearm <input type="checkbox"/> Upper arm <input type="checkbox"/> Leg/Thigh <input type="checkbox"/> Other—specify: _____ <input type="checkbox"/> Subclavian <input type="checkbox"/> Internal Jugular <input type="checkbox"/> Femoral <input type="checkbox"/> Other – specify: _____

NOTE: Please show Configuration of access, Vessels Involved, and Direction of Access Flow

NOTES:

Were diagnostic evaluations performed prior to procedure? If yes, describe: _____

Brief description of procedure (if preferred access not placed, explain reason): _____

Procedure findings (if relevant): _____

Was procedure successful? Yes No (circle one)

Recommendations/Comments: _____

Additional care information/instructions: _____

Special cannulation instructions: _____

Patient follow-up:

1. Patient to schedule appointment in ___ days/weeks with Surgeon/Nephrologist (circle one)
2. Patient appointment has been scheduled _____ (date) with Dr. _____

Other Notes: _____

