azura vascular care

Patient scheduling form

Dialysis access

Today's Date _____

Patient Name _____ **Date of Birth** _____

Patient Address _____ **City** _____ **State** _____ **Zip Code** _____

Home # _____ **Office #** _____ **Cell #** _____

Dialysis Clinic _____ ○ **M/W/F** ○ **T/T/F**

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

Access Procedure: ○ AV Fistula / ○ AV Graft / ○ AV Fistula Creation / ○ PD Catheter Placement

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

Catheter Procedure:

Site: ○ **Tunneled** / ○ **Non-Tunneled** ○ **Right** / ○ **Left** ○ **Chest** / ○ **Groin**

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

Indication:

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

* Reason no longer required: _____

Clinical Information:

X-Ray Contrast Allergy	○ Yes	○ No		○ Reaction _____
Diabetic	○ Yes	○ No		○ Latex Allergy
Any Anticoagulants?	○ Coumadin	○ Plavix	○ ASA	○ Other _____

Transportation Needs:

Is the patient able to provide or arrange his/her own transportation? ○ Yes ○ No ○ Azura arranged transport

○ Ambulatory ○ Cane ○ Walker ○ Stretcher ○ Electric wheelchair ○ Manual wheelchair

Post- procedure destination: ○ Home ○ Dialysis clinic ○ Other _____

Dialysis Clinic – Please complete the following information:

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

Nephrologist _____ Surgeon _____

Competent to sign consent? ○ Yes ○ No

If No, whom? _____ Phone _____

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. Prescription for Procedure **2. Insurance Cards** **3. Pt. Demographic Sheet** **4. Medication List** **5. Most recent H&P**

Azura Use Only – Appointment Date/Time _____ **Pickup Time** _____ **Confirmed by** _____