PROCEDURES ARE ONLY TO BE ORDERED AT THE BEHEST OF THE PATIENT'S PHYSICIAN. DO NOT FILL OUT THIS FORM WITHOUT A VERBAL OR WRITTEN ORDER TO DO SO OR WITHOUT THE KNOWLEDGE, CONSENT, AND AUTHORIZATION OF THE PATIENT'S NEPHROLOGIST, SURGEON, OR OTHER PHYSICIAN FOR ACCESS ADVANTAGE TO MATURE, MAINTAIN, AND/ OR TROUBLE SHOOT THIS PATIENT'S HEMODIALYSIS AV ACCESS.

ACCESS ADVANTAGE of Indianapolis

ACCESS ADVANTAGE at Capitol Street Surgery Center
2007 N. Capitol Ave., Indianapolis, IN 46202
Scheduling Phone: 317.644.1404 Scheduling Fax: 317.759.5204
Sanjay Mohindra, MD **Tyler Kelly, NP**

Please fax this form with prior fistulagram and surgical reports, insurance info, history and physical, and med list to 317-759-5204.

☐ New Schedule ☐ Reschedule ☐ Schedule Change ☐ Cancellation - Reason _____

Patient Name: _____ DOB: _____
Pt Phone #: _____ Dialysis Center: _____ PH _____
Alternative Contact Phone #: _____ Contact Name / Relationship: _____
Does Patient Live in an ECF? ☐ Yes ☐ No If so, Name / Phone #: _____
Requested Procedure Date: ____/____/____ or first available Allergies: _____
Referring Physician: _____ Shift: MWF TTS 1 2 3 Nocturnal
Who Will Be Transporting Patient?: _____
If procedure is for today: Last time patient ate or drank anything?_____
(Please remind patient not to eat or drink anything between now and until after their procedure!)

Please Note + Inform Patient: No food or drink for 6 hrs before procedure start time and that a responsible party must be present to receive them and sign discharge instructions after the procedure.

Dialysis Center Scheduler _____ ☐ Demographics Attached ☐ Insurance Card Attached ☐ H&P/Med list Attached ☐ Orders Attached

CURRENT ACCESS TO BE EVALUATED: (check all that apply)

TYPE OF ACCESS
☐ Permcath
☐ AV Graft
☐ AV Fistula
☐ PD Cath
When access placed:_____
Created by:_____
Facility access placed:_____
☐ Other: _____
_____

LOCATION
☐ Right ☐ Left
☐ Arm
☐ Upper ☐ Forearm
☐ Leg
☐ IJ Vein
☐ Femoral Vein
☐ Translumbar
☐ Hepatic Vein
☐ Other _____

ADDITIONAL ACCESS DETAILS
Past IR Interventions: _____
_____
_____
Past Surgical Revisions: _____
_____
_____
☐ Other: _____
_____
_____

ANTICOAGULATION
☐ None
☐ Aspirin
☐ Plavix
☐ Warfarin/Coumadin
☐ Lovenox/Heparin
☐ Eliquis
☐ Other
Reason: _____
Last dose:_____

CURRENT PROBLEM: (check all that apply)

PERMCATH
☐ Non Functioning
☐ Infection
☐ Exit Site
☐ Blood Cultures
☐ Antibiotic TX:
_____
☐ Bleeding from exit site
☐ Poor Blood Flow
☐ Red Port ☐ Blue Port
☐ TPA'D x_____ at Dialysis
☐ R/O Venous Thrombosis
☐ Dislodged Cath
☐ Cuff exposed ☐ Y ☐ N
☐ Cath Out
☐ Cracked Hub
☐ Antibiotic ☐ Y ☐ N
Antibiotic TX: _____
☐ Other: _____
_____
_____

AV GRAFT / FISTULA
☐ High Venous Pressure
☐ Prolonged Bleeding
How long? _____
☐ Difficult Cannulation
☐ Low Bloodflow/KT/V
or URR (circle all that apply)
☐ Pain _____
☐ Infiltration
☐ Not Mature
☐ Clotted Access
☐ Pulling Clots
☐ Clotting Off Machine
☐ Swollen Extremity
☐ New Access Evaluation
☐ Skin Breakdown
☐ Possible Infection
☐ Pseudoaneurysm
☐ Aneurysm Evaluation
☐ New ☐ Enlarging
☐ Decrease Access Flows:
Access flow numbers
_____
☐ Δ In Bruit/Thrill
☐ Poor Arterial Flow
☐ R/O Central Vein Stenosis
☐ Steal Syndrome
☐ Other: _____

PROCEDURE REQUESTED
☐ **Access Management**
☐ Fistulogram
☐ Balloon Assisted Maturation
☐ Thrombectomy/Declot
New Access Evaluation/
☐ Clear For Use
☐ Steal Study
☐ Skin Marking
☐ Permcath Placement
☐ Permcath Exchange
☐ Remove Current Catheter
☐ Permcath Repair
☐ Permcath Check
☐ Place New Tunneled Catheter
☐ Other_____
_____
_____
_____

ADDITIONAL INFO
Does patient have history of **allergy to contrast dye?**
☐ Yes ☐ No
Reaction:_____
Steroid Prep Needed? ☐ Yes ☐ No
☐ Given ☐ Arranged ☐ Orders Needed
If clotted was K+ drawn?
☐ Yes/result _____
☐ No
Is patient positive for: ☐ MRSA ☐ VRE
Culters Requested?
☐ Yes ☐ Blood ☐ Catheter ☐ Other
Date of last dialysis
tx:____/____/____
Diabetic ☐ Yes ☐ No
Insulin ☐ Yes ☐ No
CKD ☐ Yes ☐ No
Tobacco HX ☐ Yes ☐ No
☐ Current ☐ Former
Yrs Smoked:____ Pks Per Day:____
Quit Time:_____

FOR OFFICE USE ONLY

CSSC Scheduler _____
Confirmation #_____
Appt date ____/____/____ Appt time _____
☐ Faxed to Patient's HD Unit

Additional concerns, clinical details and notes: _____
_____
_____
_____