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 ☐ New Access ☐ Thrombectomy ☐ Revision ☐ Other- specify: ____________________ **INTERVENTIONAL (Endovascular)** ☐ Thrombolysis / Thrombectomy ☐ PTA ☐ Stent ☐ Catheter insertion or revision ☐ Diagnostic Fistulogram only ☐ Other- specify: ____________________	☐ A/V Graft ☐ A/V Fistula ☐ Port device ☐ Central venous Catheter If new catheter, priming volume: ________ml ☐ Cuffed ☐ Non-cuffed **Graft Material *(if applicable)*** ☐ PTFE ☐ Other – specify: ________________ ________________	**Graft *(if applicable)*** ☐ Loop ☐ Straight ☐ Curved **Fistula Construction *(if applicable)*** ☐ Radio-cephalic ☐ Brachio-cephalic ☐ Transposed Type: ____________ ________________ ________________ ☐ Other – specify: ________________	☐ Right ☐ Left ☐ Forearm ☐ Upper arm ☐ Leg/Thigh ☐ Other—specify: ________________ ☐ Subclavian ☐ Internal Jugular ☐ Femoral ☐ 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 with Surgeon/Nephrologist (circle one) in ___ days/weeks (circle one).
2. Patient appointment has been scheduled ________(date) with Dr. _______________

Other Notes: ----------------------------