

San Diego Vascular Access Center
6402 EL CAJON BLVD SUITE 100 SD, CA 92115
(619) 582-4490

Dialysis Access Scheduling Information

PATIENT'S NAME _____

S.S. # _____ - _____ - _____ D.O.B. _____

ADDRESS _____

HOME Ph. (____) _____ - _____

DIALYSIS CENTER: _____ Ph. (____) _____ - _____

DIALYSIS DAYS _____ MWF OR _____ TTHS TIME: _____

Appointment
Date: _____
Time: _____

INSURANCE

PRIMARY _____	SECONDARY _____
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PRIMARY NEPRHOLOGIST _____ VASCULAR SURGEON _____

DESIRED PROCEDURE: (PLEASE CHECK ALL THAT APPLY)

CATHETER PLACEMENT

CATHETER EXCHANGE: POOR FLOW INFECTION OTHER (SPECIFY) _____

CATHETER REMOVAL: INDICATION: MATURE ACCESS DC DIALYSIS
 OTHER(SPECIFY) _____

ANGIOGRAM: FISTULA OR GRAFT INDICATION: SWELLING LOW AF
 LOW QB/BFR HIGH VP LOW KT/V OTHER(SPECIFY) _____

DELOT: FISTULA OR GRAFT

VEIN MAPPING

ULTRASOUND: LOWER EXTREMITY LOCATION: RIGHT LEFT BILATERAL

INDICATION: PERIPHERAL VASCULAR DISEASE NUMBNESS/TINGLING IN EXTREMITY
 NON-HEALING ULCER CRAMPING COLDNESS TO EXTREMITY
 REST PAIN SKIN COLOR CHANGES CLAUDICATION

*ALERGIC TO CONTRAST (PLEASE CIRCLE ONE) YES NO

**IF YES PLEASE CALL ACCESS CENTER

MODE OF TRANSPORTATION _____ PHONE # _____

COMMENTS:

Referring Physician's Signature, if available: _____

Referral Completed by: (Verbal Order – Nurse) _____ DATE: _____

PLEASE FAX BACK TO (619) 582-4737

Thank you,
San Diego Vascular Access Center