Bay Area Vascular Center

Port Scheduling Form

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

Today's date: _____ Requested procedure date: _____

Patient Name: _____

Patient Phone No.(Home): _____ (Cell): _____

Patient Address: _____

Allergies: _____

Any anticoagulants?: _____

☐ **PORT** ☐ Single Lumen ☐ Double Lumen

☐ **PICC** ☐ Single Lumen ☐ Double Lumen ☐ Power Injectable ☐ Weekly Flush

☐ **GROSHONG CATHETER** ☐ Single Lumen ☐ Double Lumen

☐ **QUINTON CATHETER**

☐ **OTHER** _____

Location: ☐ Right Side ☐ Left Side ☐ No Preference

Information needed - please fax:

- Insurance information
- Most recent H&P or office note if available
- Diagnosis Code ICD - 10_____

Labs needed - please fax:

- CBC
- INR

Referred By: (please sign *and* print your name below, and include your phone and fax number)

Physician: (signature) _____ (print name) _____

Phone: _____ Fax: _____

Nurse Practitioner: (signature) _____ (print name) _____

Phone: _____ Fax: _____

Bay Area Vascular Center • 8537-C Gulf Freeway • Houston, Texas 77017
Phone: 832.386.0900 • Fax: 832.386.0907

*BAVC Use Only – Appointment Date/Time:*_____*Confirmed By:*_____

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