Bay Area Vascular Center

Patient 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: ______ **Unit/Day of Week:** ______ **Shift:** ______

Patient Name: ______________________ **D.O.B.** ________ **Phone No.:** ______________

Patient Address: ______________________ **City:** ______________ **State:** ______ **Zip:** ______

(If nursing home, please indicate and use that address and phone number.)

Access Procedure: ● AV Fistula / ● AV Graft

Location: ☐ Right / ☐ Left ☐ Forearm ☐ Upper Arm ☐ Chest ☐ Thigh

Desired Procedure: ☐ Declot ☐ Fistulogram/Graftogram ☐ Venogram ☐ Ultrasound ☐ Vascular 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

Prior Access Surgeries: ______________________

____

Catheter Procedure:

Site: ☐ Tunneled / ☐ Non-Tunneled ☐ Right / ☐ Left ☐ Chest / ☐ Groin

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal ☐ Other ______

Indication:

☐ Clotted Catheter	☐ Poor Function	☐ Painful Catheter
☐ Broken Catheter	☐ No Longer Required	☐ Infection
☐ Exchange temporary catheter for permanent catheter		☐ Other ______

Clinical Information:

X-Ray Contrast Allergy	☐ Yes	☐ No	☐ Reaction? ______	
Diabetic	☐ Yes	☐ No		
Any Anticoagulants?	☐ Coumadin	☐ Plavix	☐ ASA	☐ Other ______

Transportation Needs:

Is the patient able to provide or arrange their own transportation? ☐ Yes ☐ No

☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair - Hoyer Lift Sling? ☐ Stretcher

☐ **BAVC Arranged Transport:** Company ______________ Phone ______________ Initials ________

Post- procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other ______________

Dialysis Clinic – Please complete the following information:

Referring Dialysis Clinic: ______________ **Phone:** ______________ **Fax:** ______________

Nephrologist: ______________ **Surgeon:** ______________

Competent to Sign Consent? ☐ Yes ☐ No **If No, Whom?** ______________ **Phone:** ______________

Referrer Signature: ______________________

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

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

Please e-mail the completed form to: Bayareavascular@fvc-na.com

BAVC Use Only – Appointment Date/Time:______________ Pickup Time:__________ Confirmed By:______________

8537-C Gulf Freeway • Houston, Texas 77017
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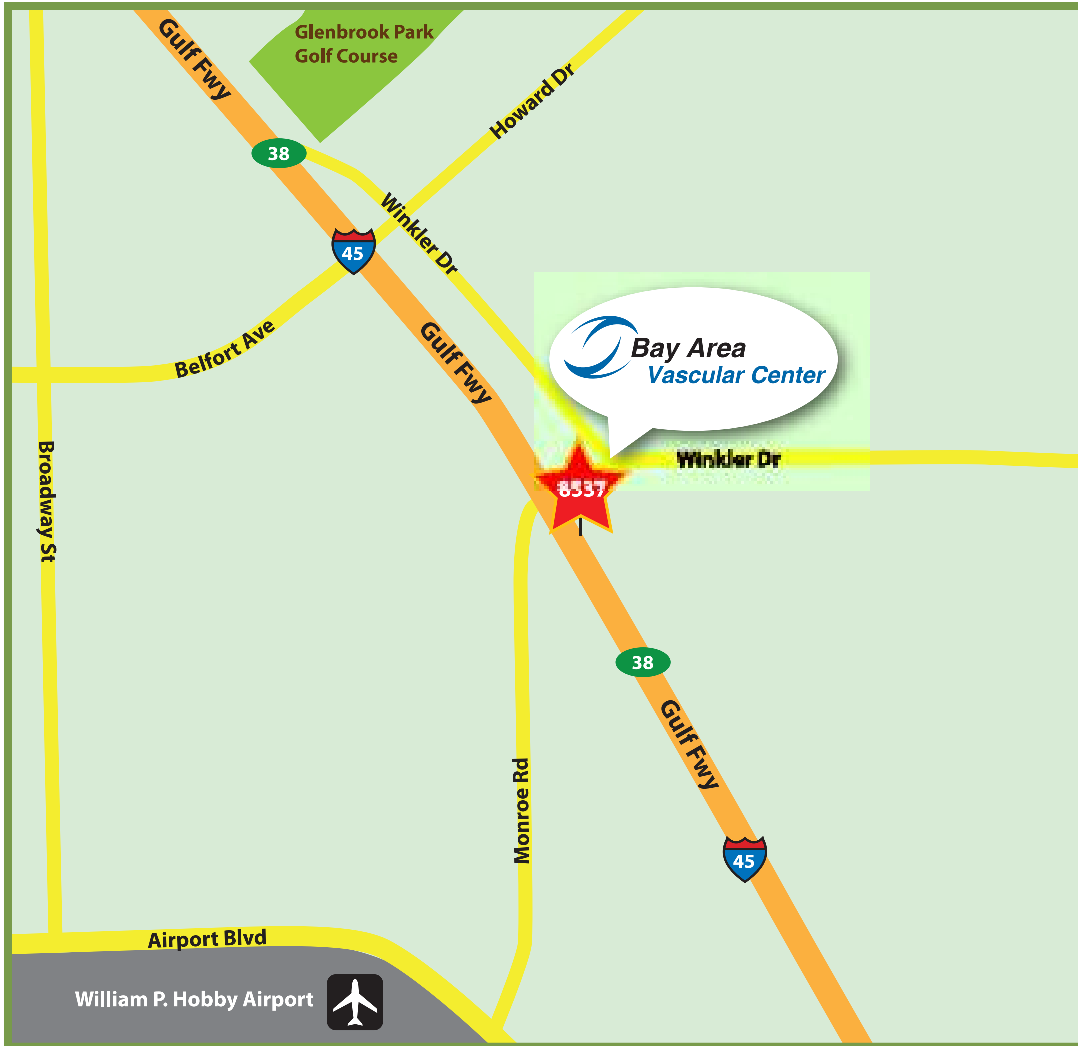

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