Connecticut Access Care
Vascular & Interventional Specialists

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: _____ **Requested procedure date:** _____ **Procedure time:** _____

Accredited by
The Joint Commission

Patient Name: _____ **Patient D.O.B.:** _____

Patient Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Patient Phone No.: _____ ***(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 ☐ Vein 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
☐ Low Flows	☐ Poor Labs	☐ Other_____

Prior Access Surgeries: _____

Catheter Procedure:

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

Desired Procedure: ☐ Insertion ☐ Catheter Change ☐ Removal ☐ Other_____

Indication:

☐ Clotted Catheter	☐ Painful Catheter	☐ Infection
☐ Broken Catheter	☐ No Longer Required	☐ Other_____
☐ Exchange temporary catheter for permanent catheter		

Clinical Information:

X-Ray Contrast Allergy	☐ Yes	☐ No	☐ Reaction?_____
Diabetic	☐ Yes	☐ No	
Home O_2	☐ 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 ☐ Stretcher

☐ **CAC Arranged Transport:** Company_____ Phone_____ Initials_____

Post- procedure Destination: ☐ Home ☐ Dialysis Clinic ☐ Other_____

Dialysis Clinic – Please complete the following information:

Dialysis Center: _____

Referred by: _____ **Phone:** _____ **Fax:** _____

Nephrologist: _____ **Surgeon:** _____

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

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

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

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