American Access Care
Vascular & Interventional Specialists

Scheduling Form

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

Today's date: _____ Requested procedure date: _____

Patient Name: _____

Patient Phone No.: _____

Patient Address: _____

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

Accredited by The Joint Commission

Access Procedure: ○ AV Graft / ○ AV Fistula

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

Desired Procedure: ❑ Declot ❑ Fistulogram/Graftogram ❑ Venogram

❑ *Other* _____

Indication:

❑ Clotted Access	❑ Pain	❑ Non Maturing Fistula
❑ High Venous Pressure	❑ Infiltration	❑ Access Surveillance
❑ Prolonged Bleeding	❑ Difficult Cannulation	❑ Steal Syndrome
❑ Recirculation	❑ Swollen Extremity	❑ Aneurysm

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:

Will Patient provide own transportation? ❑ Yes ❑ No

❑ Ambulatory ❑ Cane ❑ Walker ❑ Wheelchair ❑ Stretcher

❑ AAC Arranged Transport: Company _____ Phone _____ Initials _____

Post- procedure Destination: ❑ Home ❑ Dialysis Clinic ❑ Other _____

Dialysis Center: the following information MUST BE COMPLETED IN FULL

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

American Access Care • 9940 Franklin Square Dr., Suite H • Nottingham (White Marsh), MD 21236
Tel: 410.931.9729 • Fax: 410.931.2133

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