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

Appointment

Date: _____

Time: _____

Dialysis Access Scheduling Information

PATIENT'S NAME _____

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

ADDRESS _____

HOME Ph. (____) _____-_____

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

DIALYSIS DAYS _____**MWF OR** _____**TTHS** **TIME:** _____

INSURANCE

PRIMARY _____ **SECONDARY** _____

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)_____

__ **DECLOT:** __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