Chicago 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.**

Accredited by
The Joint Commission

Today's date: _____ **Requested procedure date:** _____ **Procedure time:** _____

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 Creation Consult:

Surgical: ☐ **Percutaneous:** ☐ **Consult for both:** ☐ Yes ☐ No

Existing Access Procedure:

☐ Thrombectomy/Declot ☐ Fistulogram/Graftogram ☐ 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 _____

Recent Access Surgeries: _____

Catheter Procedure:

Hemodialysis: ☐ **PD:** ☐

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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Pre-Procedure Instructions for the Patient

1. Please be NPO for the procedure (nothing to eat or drink for 6-8 hours before the scheduled procedure time.)
2. You may take your physician prescribed medications pre-procedure, with a small amount of water, *EXCEPT for the following blood thinners:* Coumadin (Warfarin), Plavix, Aspirin and Lovenox.
3. Please bring a list of all current medications with you to your appointment.
4. If you are taking diabetic medications – please call ahead to Chicago Access Care for specific instructions.
5. Please let Chicago Access Care know ahead of time if you have any known allergies.
6. Please bring your insurance cards with you to your appointment.