

## Indiana Surgery & Vascular Center

1420 N. Senate Ave., Suite A Indianapolis, IN 46202  
 Phone: 317-634-0920 • Fax: 317-634-0921

**IF THIS IS A TIME SENSITIVE REQUEST, PLEASE CALL THE CENTER DIRECTLY.**

**\*\*INCOMPLETE FORMS AND/OR MISSING INFORMATION MAY DELAY THE SCHEDULING PROCESS \*\***

TODAY'S DATE \_\_\_\_\_ REQUESTED DATE \_\_\_\_\_

PATIENTS NAME \_\_\_\_\_

PATIENTS ADDRESS \_\_\_\_\_

\_\_\_\_\_

PATIENTS PHONE NUMBER \_\_\_\_\_

DIALYSIS CENTER \_\_\_\_\_

LAST DATE OF SUCCESSFUL DIALYSIS \_\_\_\_\_

PATIENT REGULAR DIALYSIS DAYS

M-W-F     T-T-S     M-F  
 AM     MID     PM

PLEASE FAX THE FOLLOWING INFORMATION TO OUR OFFICE:

1. DEMOGRAPHIC SHEET
2. MEDICATION LIST
3. INSURANCE CARD(S)

### ACCESS TYPE

AVG     AVF     CATHETER

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RT FOREARM     LT FOREARM     RT CHEST

RT UPPER ARM     LT UPPER ARM     LT CHEST

RT THIGH     LT THIGH

INDICATION:

INFILTRATION     REPAIR

INFECTION     ANEURYSM     NO LONGER NEEDED

CLOTTED     PROLONGED BLEEDING     PAINFUL

DIFFICULT CANNULATION     NON MATURING FISTULA     SWELLING

DECREASED ACCESS FLOW     STEAL SYNDROME     OFFICE VISIT

OTHER \_\_\_\_\_

### CLINICAL INFORMATION

CONTRAST OR IV DYE ALLERGY PREP ORDERED?

YES \_\_\_\_\_  NO

DIABETIC?

YES

NO    Reaction

ANTICOAGULANTS?

COUMADIN

PLAVIX

OTHER \_\_\_\_\_

COMPETENT TO SIGN CONSENT?

YES

NO    IF NO -WHOM \_\_\_\_\_

LAST TWO ACCESS FLOW READINGS (REQUIRED)

PHONE \_\_\_\_\_

READING \_\_\_\_\_

DATE \_\_\_\_\_

READING \_\_\_\_\_

DATE \_\_\_\_\_

### TRANSPORTATION

Can patient provide own transportation to and from facility?

Yes     Needs transportation

### DIALYSIS CENTER

Fax: \_\_\_\_\_ Nephrologist: \_\_\_\_\_

Phone: \_\_\_\_\_ Scheduled by: \_\_\_\_\_ Surgeon: \_\_\_\_\_