



Vascular Institute of Virginia

14085 Crown Ct. • Woodbridge, VA 22193
1440 Central Park Blvd. Suite 108 • Fredericksburg, VA 22401
13135 Lee Jackson Memorial Hwy. Suite 145 • Fairfax, VA 22033
703-763-5224 • Fax 703-763-5374 • www.teamviv.com

HD Scheduling/Order Form

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Today's Date: Appointment Date:

Patient Name: Date of Birth:

Patient Address:

Patient Phone No.: (Home) (Cell) (Work)

Access Procedure:

Access Type: AV Graft AV Fistula PD Catheter Other

Location: Right / Left Forearm Upper Arm Chest Thigh

Desired Procedure: Declot Fistulagram/Graftogram Venogram Vein Mapping

Surgical Consult

Other

Indication: Clotted Access Pain Non Maturing Fistula

High Venous Pressure Infiltration Poor Clearances

Prolonged Bleeding Difficult Cannulation Steal Syndrome

Recirculation Swollen Extremity Aneurysm

Access Procedure:

Access Type: Tunneled / Non-Tunneled Right / Left Chest / Groin

Desired Procedure: Insertion Catheter Change Removal Other

Indication: Clotted Catheter Poor Function Infection

Broken Catheter No Longer Required Other

Clinical Information:

X-Ray Contrast Allergy? Yes No Reaction?

Diabetic? Yes No

Any Anticoagulants? Coumadin Plavix ASA Other

Competent to Sign Consent? Yes No ___ If No, Whom? Phone

Transportation Needs:

Will Patient provide own transportation? Yes No

Ambulatory Cane Walker Wheelchair Stretcher

VIV Arranged Transport: Company Phone Initials

Post - procedure Destination: Home Dialysis Clinic Other

Dialysis Center: Please fill out the following information in full:

Referred by: Phone Fax:

Nephrologist: Surgeon:

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. Insurance Cards
2. Pt. Demographic Sheet
3. Medication List
4. Most Recent H&P

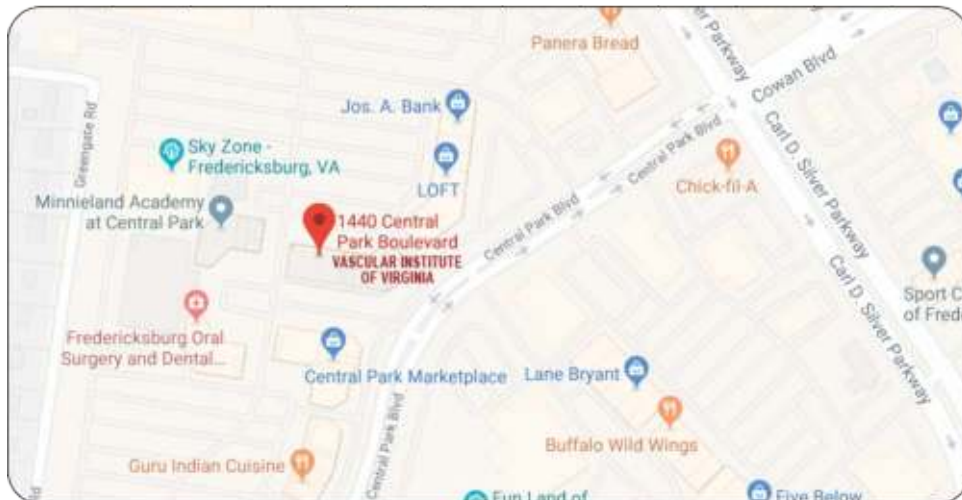
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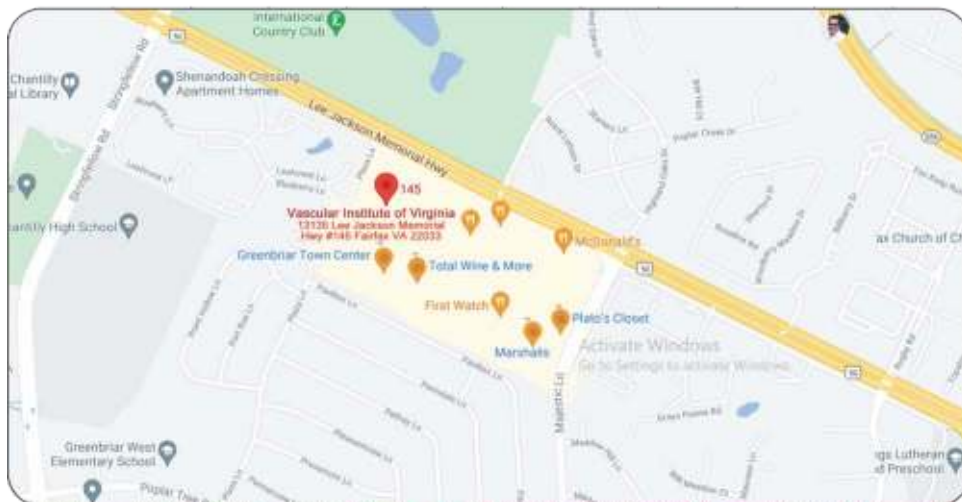
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