Medical District
VASCULAR CENTER

1105 S Western, Chicago, Illinois 60612 • Telephone: 773-329-4660 • Fax: 773-329-4661

Date: _____ Requested Procedure Date: _____

Dialysis Center Name: _____ Referred by: _____

Nephrologist: _____ Phone: _____ Fax: _____

*Signature: _____

Patient Name: _____ DOB: _____

Patient Address: _____ Patient Phone: _____

*****May need the following faxed to our office:**

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

Access Procedure: ☐ **Graft** ☐ **Fistula**

Location: ☐ Right ☐ Left ☐ Forearm ☐ Upper Arm ☐ Leg

Requested Procedure: ☐ Venogram for Mapping ☐ Fistulogram/Graftogram ☐ Declot
☐ Other/please specify _____

Indication: ☐ Clotted Access ☐ Pain ☐ High Venous Pressure ☐ Prolonged Bleeding ☐ Aneurysm
☐ Non maturing fistula ☐ Infiltration ☐ Difficult Cannulation ☐ Swollen Extremity
☐ Other/please specify _____

Catheter Procedure:

Site: ☐ Right ☐ Left ☐ Chest ☐ Groin **Procedure:** ☐ Port ☐ PICC Line ☐ Central Line ☐ Dialysis Cath

Action: ☐ Insertion ☐ Catheter Change ☐ Catheter Check ☐ Removal ☐ Other _____

Indication: ☐ Malfunctioning Catheter ☐ No longer Needed ☐ Catheter Pain ☐ Infection
☐ Convert Temporary Catheter to Permanent Catheter ☐ Other _____

Clinical Information:

Contrast Allergy? ☐ Yes, Please Explain _____ ☐ No

Diabetic? ☐ Yes ☐ No

Able To Sign Consent? ☐ Yes ☐ No, then:

Whom? _____ Phone _____

Transportation

☐ Ambulatory ☐ Walker ☐ Wheelchair ☐ Stretcher ☐ Other _____

Transportation Provided By: ☐ MDVC Company _____ Phone _____

Post Procedure Destination: ☐ Dialysis Center ☐ Home ☐ Other _____