

Northeast Indiana Access Care

1833 Magnavox Way • Fort Wayne, IN 46804
 Phone: 260-918-0997 • Fax: 260-459-7885

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
-
- 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: _____