



**Ruchdi Barakat, MD**

**John Nguyen, DO**

**Brett Stephens, MD**

Today's Date: \_\_\_\_\_ Requested procedure date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone No.: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Dialysis Schedule:  M  W  F  T  T  S Shift:  1  2  3  4  Nocturnal  PD

**ISOLATION PRECAUTIONS:**  Yes  No Type: \_\_\_\_\_

**Access Procedure: •AV Graft / •AV Fistula**

Type of Access:  AV Graft  AV Fistula Placement Date: \_\_\_\_\_

Location:  Right /  Left  Forearm  Upper Arm  Chest  Thigh

Desired Procedure:  Declot  Fistulogram/Graftogram  Venogram  
 Other: \_\_\_\_\_

Indication: {  High Venous Pressure/Arterial Pressure  Difficult Cannulation  Pulling Clots  
 Prolonged Bleeding  Recirculation  Non Maturing Fistula  Pain  
 Swollen Extremity  Infiltration  Access Surveillance  
 Clotted Access  Steal Syndrome  Aneurysm

**Catheter Procedure:**

Site:  Tunneled /  Non-Tunneled  Right /  Left  Chest  Groin  Abdomen

Desired Procedure:  Insertion  Catheter Change  Removal  PD Catheter Consult  PD Catheter Placement

Indication: {  Poor Function  No Longer Required  Infection  New Patient/Modality Change  
 Broken Catheter  Clotted Catheter  Painful Catheter  
 Exchange temporary catheter for permanent catheter  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  HVAC Arranged Transportation

Ambulatory  Cane  Walker  Wheel Chair  Stretcher

Post - Procedure Destination:  Home  Dialysis Clinic  Other \_\_\_\_\_

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

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Nephrologist: \_\_\_\_\_ Dialysis unit: \_\_\_\_\_

If the patient is confused or forgetful, a second signature is **REQUIRED**: \_\_\_\_\_

**ALL OF THE FOLLOWING  
MUST BE FAXED TO OUR OFFICE:**

1. Insurance Cards
2. Pt. Demographic Sheet
3. Medication List
4. Most Recent H&P
5. Most Recent Hemoglobin & Potassium Levels

**\*Please notify our office if the patient has current infection and/or is hepatitis positive.\***

HVAC/HVSC use only Appointment Date/Time: \_\_\_\_\_ Pickup Time: \_\_\_\_\_ Confirmed By: \_\_\_\_\_