HEMODIALYSIS INTERVENTIONAL SCHEDULING

St. Joseph's Hospitals
BayCare Health System
IMAGING SERVICES

To schedule an appointment, please call: (813) 357-1564 or fax this form to (813) 554-8211

Patient's Name: _____ DOB: _____ SS#: _____

Insurance Provider: _____ Member ID: _____

Home Phone: _____ Home Address: _____

City: _____ Zip: _____ Dialysis: _____

Is transportation needed? YES / NO Call:_____ In Nursing Home? YES / NO

Nephrologist_____ Vascular Surgeon_____ Dialysis Ctr._____

Physician Name:_____ Office Phone:_____
(Print Name)

Physician Signature:_____

DIAGNOSIS

Desired Procedure	Indication		Urgency
Angiogram (Fistulagram)	Aneurysm	Low Access Flow	Stat
Angioplasty	Clotted Access	Non-Maturing Access	Routine
Declot	Decreased URR or Kt/V	Pain	Specify:_____
Catheter Placement	Difficult Cannulation	Recirculation	
Catheter Exchange	Increased Arterial Pressure	Steal Syndrome	
Catheter Removal	Increased Venous Pressure	Swollen Extremity	
Vein Mapping	Infection		
OTHER_____	Infiltration	Other_____	

ACCESS INFORMATION

AV Graft_____ AV Fistula_____ Catheter_____ Location_____

Contrast Allergies: YES NO *(If yes, call for pre-meds orders)*

_____Indicate if Access placed is less than 4 weeks old

If the Patient has an Advanced Directive, please bring a copy to the appointment