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Today’s Date: \_\_\_\_\_\_\_\_

Pt. Name: Last: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_First: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Sex: M/F/O Dialysis Ctr: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Pt. Phone #: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Dialysis Ctr Phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

 Date of Birth: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Patient’s Nurse/Tech: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Requesting for (date): \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Dialysis Schedule: MWF TTS

Patient’s Address: \_ \_ \_\_ \_ \_ \_ \_\_ \_ \_ \_ \_ \_ Dialysis Shift: 1st 2nd 3rd 4th

 \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ Last Dialysis was on: \_ \_ \_ \_ \_ \_ \_ \_ \_

Patient’s Nephrologist: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Nephrologist’s Phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Nursing Home/Hospice Patient: Yes / No. Facility Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

 Facility Phone: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**Type** of Access: Fistula / Graft / Dialysis Catheter

**Side** of Access: RIGHT / LEFT

**Location** of Access: Chest / Lower Arm / Upper Arm / Thigh

Care Requested: \_\_\_\_\_\_\_ Access Angiogram with possible treatment

 \_\_\_\_\_\_\_ Dialysis Catheter Check / Change

 \_\_\_\_\_\_\_ New Dialysis Catheter Placement

 \_\_\_\_\_\_\_ Dialysis Catheter Removal

 \_\_\_\_\_\_\_ Physical Exam by Dr. C or his colleague

**Problem** with Access:

\_\_\_\_\_ Prolonged **bleeding** \_\_\_\_\_ Catheter **malfunction** \_\_\_\_\_ Low **Kt/V**, Low **Clearance**

\_\_\_\_\_ High **Ven**ous **pressures** \_\_\_\_\_ Catheter-related **infection** \_\_\_\_\_ **Swollen** extremity

\_\_\_\_\_ High **Art**erial **pressures** \_\_\_\_\_ Catheter **clogged** \_\_\_\_\_ **Steal** syndrome

\_\_\_\_\_ **Aneurysm** \_\_\_\_\_ Machine **beeping** during dialysis \_\_\_\_\_ Delayed **maturation**

\_\_\_\_\_ Recirculation \_\_\_\_\_ **Pain** \_\_\_\_\_ Discharge / **Pus** at access \_\_\_\_\_ Access **Clotted** \_\_\_\_\_ Cath. no longer required **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Transportation Needed: YES / NO Ambulatory / Wheel Chair / Stretcher Pat. Weight: \_\_\_\_\_\_ Lb/Kg

**X-ray Contrast Allergy:** YES / NO 🡪 Patient is premedicated : YES / NO

This form is completed by (Signature) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_