



A. Ramsey Abadir, MD • Chris Donikyan, DO • Vivek Patil, MD
60 Merritt Boulevard, Suite 107, Fishkill, New York 12524

PHONE: 845.896.1900 | FAX: 845.896.1990 | americanendovascular.com



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NOTE: In compliance with the Universal Protocol for Wrong Site Surgery, all areas highlighted in BLUE must be completed in full by the referrer.

To be completed by referring physician (please print all information)

PATIENT NAME (first and last): _____

PHONE (home): _____ (mobile): _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

LANGUAGE ACCOMMODATION? YES NO Specify: _____

REFERRING PROVIDER: _____ NPI#: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

NEPHROLOGIST: _____ SURGEON: _____

Access Procedure: AV GRAFT AV FISTULA FISTULA CREATION

LOCATION: R L FOREARM UPPER ARM CHEST THIGH

DESIRED PROCEDURE: DECLOT FISTULOGRAM VENOGRAM ULTRASOUND
 VEIN MAPPING OTHER _____

INDICATION

- CLOTTED ACCESS PAIN NON-MATURING FISTULA
- HIGH VENOUS PRESSURE INFILTRATION ACCESS SURVEILLANCE
- PROLONGED BLEEDING ANEURYSM DIFFICULT CANNULATION
- STEAL SYNDROME RECIRCULATION SWOLLEN EXTREMITY

PRIOR ACCESS SURGERIES: _____

Catheter Procedure:

LOCATION/SITE: R L TUNNELED NON-TUNNELED CHEST GROIN PD

DESIRED PROCEDURE: INSERTION CATHETER CHANGE REMOVAL EXCHANGE
 OTHER _____

INDICATION

- CLOTTED CATHETER POOR FUNCTION PAINFUL CATHETER
- BROKEN CATHETER INFECTION NO LONGER REQUIRED
- EXCHANGE TEMPORARY CATHETER FOR PERMANENT CATHETER
- OTHER _____

Clinical Information:

XRAY/CONTRACT ALLERGY? Yes No REACTION: _____ DIABETIC? Yes No

ANY ANTICOAGULANTS? Yes No Coumadin Plavix ASA Other _____

COMPETENT TO SIGN CONSENT? Yes No If the patient is confused or forgetful, a second signature is required

IS PATIENT ABLE TO PROVIDE OR ARRANGE FOR OWN TRANSPORTATION? Yes No

AMBULATORY CANE WALKER WHEELCHAIR STRETCHER TRANSPORT NEEDED

TRANSPORT COMPANY NAME _____ PHONE _____ INITIALS _____

POST PROCEDURE DESTINATION: Home Dialysis Clinic Other _____

PLEASE FAX THE FOLLOWING TO OUR OFFICE:

Prescription for Procedure, Insurance Cards, Medication List, Demographic Sheet, Most Recent H&P