AMH Interventional Radiology
Dialysis Patient Scheduling Request
PLEASE FAX BACK TO 215.481.4653

Please fill in all requested information to reduce the need for additional phone calls. Questions? 215.481.2071

Patient Name_____________________________ DOB_____________ MR#_______________

Referring Physician________________________________ Procedure Date_______________

Person Providing Info___________________ Pt Location________ Pt Tel #_________________

Procedure Requested (Please complete this section, additional information may be provided by attaching current medication and dialysis history forms).

Fistulogram Only	☐	Fistulogram & PTA If Indicated	☐
Thrombolysis & PTA if Indicated	☐	Other (Be Specific)	
Reason for Procedure (IMPORTANT, Please Complete)			

Graft/Catheter Information

Location & Type		Date of Placement	
Hx of Infection		Last Revision/Intervention;	

Medical History

Significant Medical Problems			
Allergies	☐ **NKDA**	Meds (attach list)	

For Thrombolysis Patients

Recent CVA within last 90 Days	☐ **No** ☐ **Yes**	GI Bleed within last 30 days?	☐ **No** ☐ **Yes**	Stool Heme	☐ **Neg** ☐ **Pos** ☐ **N/A**
Recent Major Surgery (30 Days)	☐ **No** ☐ **Yes**	Pulmonary Disease	☐ COPD ☐ Requires Oxygen		

Lab

Relevant Data, esp. INR and K+	**INR:** **K+:**

If Possible Angioplasty or Thrombolysis Patient Information Sheet Info Given	

_______________________________________ ____________________________

Completed by Date