

## VASCULAR ACCESS PLANNING CHECK LIST

Patient Name: \_\_\_\_\_

Nephrologist: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Previous or  
current access: \_\_\_\_\_ Date: \_\_\_\_\_

Vein mapping date: \_\_\_\_\_

Best vein: \_\_\_\_\_ Size: \_\_\_\_\_ Dilatation: \_\_\_\_\_

2<sup>nd</sup> best vein: \_\_\_\_\_ Size: \_\_\_\_\_ Dilatation: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Appt. date: \_\_\_\_\_

Surgery Plan A: \_\_\_\_\_

Surgery Plan B: \_\_\_\_\_

Tunnelized catheter needed: \_\_\_\_\_

Estimated time to hemodialysis: \_\_\_\_\_

Surgery schedule: \_\_\_\_\_