

VASCULAR ACCESS PLANNING
CHECK LIST

Patient Name: _____

Nephrologist: _____

Primary Care Physician: _____

Previous or
current access: _____ Date: _____

Vein mapping date: _____

Best vein: _____ Size: _____ Dilatation: _____

2nd best vein: _____ Size: _____ Dilatation: _____

Surgeon: _____ Appt. date: _____

Surgery Plan A: _____

Surgery Plan B: _____

Tunnelized catheter needed: _____

Estimated time to hemodialysis: _____

Surgery schedule: _____