DARTMOUTH-HITCHCOCK • MANCHESTER

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Venous Access Device Consultation Request Form

Date of Request: _____

Patient Name: _____ DOB: _____

Patient Contact Phone Number: _____

Referring Provider: _____ PCP:_____

Preferred Surgeon: ☐ First Available or Please name: _____

Please evaluate for placement of a venous access device. The following summarizes the patient's clinical situation and venous access requirements.

Diagnosis:

Type of access device requested:
Internal: ☐ Single Lumen ☐ Double Lumen
External: ☐ Single Lumen ☐ Double Lumen ☐ Triple Lumen

Has chemotherapy been started? ☐ Yes ☐ No
If YES: Estimated safe insertion date range:
If NO: Date you would like VAD placed by:

Most recent CBC results:
Date: **WBC:** **HGB:** **HCT:** **PLT:**

Has Patient had an EKG within the past 2 months? ☐ Yes ☐ No

Date/Location:

* Elliot Hospital requires EKG on all patients over 50

Has the patient had an H&P with the last 15 days? ☐ Yes ☐ No

Is patient on anticoagulants? ☐ Yes ☐ No Medication:

Is patient on antiplatelet medication? ☐ Yes ☐ No Medication:

Has patient had a previous venous access device? ☐ Yes ☐ No