



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