Fax with H&P, Coags & CBC To:

(604)-875-4092

Vancouver Radiology Inc (VRI)
Venous Access Program Communication Sheet

Name:		**Date of Birth:**
Patient Address:		
PHN:	**MRN:**	**BCCA:**
Patient Contact #:	**Referring MD:**	**Contact #:**
Height:	**Weight:**	**Allergies:**
Activity Level: □ High □ Moderate □ Low	**Mastectomy:** □Right □Left □ Both	□ **Radiation:**
□ **Anticoagulation** (ASA Plavix Coumadin etc):	□ **Artificial Valve:**	□ **Pacemaker**: □ Right □ Left

1. INITIATION OF THERAPY □ 2-4days □ <1wk □ 1-2wk □ 2-4wk □ other:

2. DURATION OF THERAPY □ <1wk □ <2wks □ <4wk □ >1mo □ other:

3. LOCATION □ Vancouver General Hospital □ UBC Hospital □ First Available Location

4. DIAGNOSIS
□ cancer:_____ □ malnutrition □ infection:_____
□ poor access □ dehydration □ renal failure □ Other:

5. INDICATION
□ chemotherapy □ plasmapheresis □ TPN
□ hydration □ antibiotics □ other:

6. DEVICE

Tunneled Central Line

□ Single Lumen
□ Double Lumen
□ Triple Lumen

□ Power Injectable (Single/Dual only)
□ Open ended □ Groshong

Dialysis/Apheresis

□ Temporary
- □ Slow Flo/Small 11 Fr (Apheresis)
- □ High Flo/Large 13.5 Fr (Dialysis)

□ Tunneled dialysis
□ Trifusion line (Special Access)

Ports

□ Single Lumen
Power Injectable (single only) □Yes □No

□ Double Lumen

Accessed □Yes □No

NOTE: access provided only if to be used within 48h

7. IMPLANT PREFERENCE

□ Right
□ Left
□ Radiologist to determine

8. ADDITIONAL INFORMATION

(eg. PORT removal, bridge anticoagulation required, previous lines, specific data)

Signature:_____ **MSP:**_____ **DATE:**_____

For Inquiries: Call (604) 875-4111 x68612 or page the Interventional Radiologist on call

Radiology Admin Staff To Complete

Date and Time:_____ □ patient notified	□ arrive at:_____ □ clinic notified	□ Preparation □ NPO	□ Ride Home □ booking form faxed