PRECISION VASCULAR ACCESS

IV Nurses at your service

INTAKE FORM

[Place patient sticker here]

TO BETTER SERVE YOU, PLEASE ENSURE THE FOLLOWING ARE SIGNED/COMPLETED WHERE INDICATED:

- ☐ INTAKE FORM
- ☐ PATIENT'S FACE SHEET (IF APPLICABLE)
- ☐ COPY OF PATIENT'S INSURANCE CARD (FRONT & BACK)
- ☐ COPY OF PATIENT'S DRIVER'S LICENSE (FRONT & BACK)
- ☐ COPY OF ORIGINAL SIGNED DOCTOR'S ORDER FOR LINE PLACEMENT
- ☐ SIGNED COPY OF PRE-FORMATTED VASCULAR ACCESS ORDER SET
- ☐ COPY OF MOST RECENT H&P
- ☐ MOST RECENT COPY OF CBC/BMP, PT/INR
- ☐ SIGNED COPY OF PATIENT INFORMATION/CONSENT FORM

PLEASE FAX COMPLETED DOCUMENTS TO **(833) 265-2736**

AS SOON AS POSSIBLE TO SCHEDULE AN APPOINTMENT

WWW.PRECISIONVASCULARACCESS.COM
PHONE: 619-693-7399 FAX: 833-265-2736

PRECISION VASCULAR ACCESS

IV Nurses at your service

INTAKE FORM

[Place patient sticker here]

DATE/TIME ORDER WRITTEN: _____

DATE/TIME ORDER RECEIVED VIA FAX/EMAIL: *(office use only)*

REFERRING MD: _____

FACILITY: _____

PATIENT DIAGNOSIS: _____

ALLERGIES: _____

LINE ORDERED: ☐ PICC LINE ☐ MIDLINE ☐ US GUIDED PIV

INDICATION: ☐ ACCESS ☐ REPLACE MALFUNCTIONING LINE ☐ LONG TERM IV THERAPY

☐ OTHER: _____

PRESCRIBED THERAPY: _____

Does this patient have a history of or currently have any of the following?

Yes	No			
☐	☐	Atrial fibrillation		
☐	☐	AV fistula		
☐	☐	Blood thinners *(i.e. Heparin, Coumadin, Xarelto, Pradaxa, Eliquis)*		***Recent INR***: _____
☐	☐	Breast Cancer with mastectomy:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Drug allergy to lidocaine		
☐	☐	Hemiplegia:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Hemodialysis		
☐	☐	History of DVT in upper arms:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Implanted port (port-a-cath)	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Increased WBC with fever within the last 24 hours		
☐	☐	Limited ROM/Contracture(s):	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Lymphadenectomy:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Pacemaker:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Paresthesia of the arms:	***Affected side***	RIGHT / LEFT / BOTH
☐	☐	Positive blood cultures collected/drawn within the last three days		

CONTACT NAME: _____ CONTACT NUMBER: _____

WWW.PRECISIONVASCULARACCESS.COM
PHONE: 619-693-7399 FAX: 833-265-2736

PRECISION VASCULAR ACCESS

IV Nurses at your service

VASCULAR ACCESS ORDER SET

[Patient information here]

- ***Orders preceded with a box must be checked to activate.***
- ***All other orders are effective unless modified. Initial each modification made to the order set (e.g., additions, deletions, strikeouts)***
- ***Statements in italics represent decision support for providers completing the order set; these statements are not part of the physician order(s). Provide legible identification, sign, date and time last page.***

DIAGNOSIS: _____

☐ Place Peripherally Inserted Central Catheter (PICC)

PICC indication:

- *Parenteral Nutrition greater than 900 mosm/L*
- *Chemotherapy*
- *Concentrated vasoactive medications*
- *Concentrated electrolytes*
- *Multiple continuous infusions*
- *Central Venous Pressure (CVP) monitoring*
- *Frequent lab draws at a minimum interval of 6 hours for greater than 24 hours*

☐ Place midline (ML) intravenous catheter

ML indication:

- *Difficult peripheral access*
- *Medium to long term intravenous (IV) therapy less than 29 days*

☐ Place peripheral intravenous catheter (PIV)

PIV indication:

- *Difficult peripheral access*
- *Short term or intermittent intravenous (IV) therapy less than one week*

Other Nursing

Post insertion:

- ✓ AVOID BLOOD PRESSURES or VENIPUNCTURES or PERIPHERAL IV's on the arm with catheter.
- ✓ May use PICC for infusion after confirmation of tip placement in superior vena cava (SVC) or cavoatrial (SVC/RA) junction. RN may pull back catheter as recommended by radiologist or MD.
- ✓ May use for power injection only when catheter labeled for power injection.
- ✓ Initiate new IV tubing on insertion.
- ✓ May use warming pad as needed for patient comfort. Elevate arm as needed for patient comfort.
- ✓ Assess external length of PICC line daily. Notify MD if catheter has migrated more than 4 cm total.
- ✓ Notify MD if arm becomes edematous, tender or red.
- ✓ DO NOT FLUSH catheter with smaller than a 10 ml syringe.
- ✓ 0.9 % NaCl 10 ml intravenous flush before and after medication administration and following discontinuation of any IV solution.
- ✓ 0.9% NaCl 10 ml intravenous flush every 12 hours when not continuously infusing fluids.
- ✓ 0.9% NaCl 20 ml intravenous flush after all blood draws.

Imaging for PICC tip confirmation

- ✓ ECG Monitoring Technology, if available, for confirmation of catheter tip placement of PICC lines.
- ✓ If ECG Monitoring Technology is not available or if patient does not meet criteria for ECG Monitoring, then:
  - Portable PA (upright) X-ray of the chest STAT for confirmation of catheter tip placement
  - Portable PA (upright) X-ray of the chest STAT for confirmation of catheter tip placement

Medications

Local anesthetics for PICC/ML/PIV insertion:

- ✓ Lidocaine 1% Solution 1 ml intradermal. May repeat up to 2 times for local anesthesia.

Discharge care and maintenance

- ✓ Patient and/or family to be given both verbal and written discharge instructions.
- ✓ Registered nurse (RN) to maintain vascular access device maintenance once weekly and as needed.
- ✓ May discharge patient from facility upon vascular access device tip confirmation.

Informed Consent

☑ ***Vascular Access Device Placement*: By checking this box, I certify that the patient and/or family has been given information regarding this procedure, including associated risks and benefits, and has had the opportunity to ask questions. Participation is voluntary and the patient is free to withdraw at any time, without giving reason and without cost. The patient will be given a copy of the consent form.**

Prescriber Signature	Printed Name	Date and Time
Clinician Signature	**Printed Name**	**Date and Time**

PRECISION VASCULAR ACCESS

IV Nurses at your service

VASCULAR ACCESS DEVICE INSERTION
PATIENT INFORMATION/CONSENT FORM

[Patient information here]

Please check (☑) the appropriate box(es) (☐) and fill in the blank(s) as needed.

I am a patient and I have the right to know about my medical condition and what my doctors are recommending to me to treat my medical condition. I have been informed of the most important risks and benefits of having a vascular access device (VAD) placed for intravenous (IV) therapy and have also been informed about other possible treatments or procedures.

I want the following VAD to be placed for IV therapy:

- ☐ Peripherally Inserted Central Catheter (PICC)
- ☐ Midline (ML) intravenous catheter
- ☐ Peripheral Intravenous (PIV) Catheter

I know there is no guarantee this procedure will work. I also know there are certain risks involved with the placement of PICC lines, midlines, and PIVs, including infection, bleeding, nerve damage, blood clots, arterial puncture, vein irritation, allergic reactions, heart attack, stroke and death. Alternatives to PICC/ML insertion are to have PIV lines inserted as needed, blood draws requiring needle sticks, and/or physician placed central catheters which may be located in the chest or neck.

If any individual(s) involved in my care is exposed to any bodily substance, I consent to having any bodily fluid(s) and/or tissue obtained and submitted for any testing deemed reasonable by my health care provider(s). I know and agree that the results of these tests will be made available to any health care provider(s) who may have been exposed to such fluids and/or tissue. I consent to the taking and storage of pictures, videos or electronic images for the purpose of medical education or training provided, attempts are made to conceal my identity.
I understand there will be other healthcare providers who may perform the procedure including physician assistants (PA), nurse practitioners (NP), Vascular Access Service registered nurses (RN) and others. All persons during the procedure will act within their own abilities/privileges and according to facility policies.

☐ I agree my doctor and/or the Vascular Access Service team member have given me the right to ask questions and I have read this whole form in its entirety. Participation is voluntary and I am free to withdraw at any time, without giving reason and without cost.

Signed:_____ Date/Time: _____
(Signature / Print name)

☐ Self ☐ Patient Representative: _____
(Relationship to patient)

Witness:_____ Date/Time: _____
(Signature / Print name)

WWW.PRECISIONVASCULARACCESS.COM
PHONE: 619-693-7399 FAX: 833-265-2736