

Monthly Vascular Access Surveillance Record

Patient Name: _____

Date of Birth: _____

Medical ID Number: _____

Current access information					Questions to evaluate early signs of Vascular Access complications										Total # "Yes"	Initial
Date	Site	Type	Insert Date	Surgeon	Rx'd time NOT delivered (access related)	Extremity swelling	Difficult cannulation	Prolonged bleeding	Decrease in Kt/V or URR	Inability to achieve QB	VP>120 @ 200QB	Recirculation >15%	Decreased Doppler <600- AVG <450-AVF			
					Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>			
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*If the answer to **2 or more** of the above questions is "yes", please see the posted vascular access algorithm and proceed accordingly.