

Add Health Authority Logo

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Add Name & Address of Vascular Access Clinic

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Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**ATTENTION: VASCULAR ACCESS NURSE**

Add Addressograph/Label

**ASSESSMENT OF MATURATION OF FISTULA OR GRAFT**

**Access Creation Date:** \_\_\_\_\_ **Surgeon:** \_\_\_\_\_

**Post Access Creation Assessment:**     2 weeks                       6 weeks                      Other \_\_\_\_\_

**Assessment Date:** \_\_\_\_\_

**Access Type** (if any):

<b>Side:</b>	<b>Left</b>	<b>Right</b>	<b>Location:</b>	<b>Fistula</b>	<b>Graft</b>	<b>AVG Only:</b>	
	<input type="checkbox"/>	<input type="checkbox"/>	Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	Straight	<input type="checkbox"/>
			Lower Arm	<input type="checkbox"/>	<input type="checkbox"/>	Looped	<input type="checkbox"/>
			Thigh	<input type="checkbox"/>	<input type="checkbox"/>		

<b>Assessment</b>	<b>Findings</b>			
Location of Pulse Assessed	<input type="checkbox"/> Radial	<input type="checkbox"/> Ulnar	<input type="checkbox"/> Pedal	
Pulse Quality	<input type="checkbox"/> Present	<input type="checkbox"/> Absent		
Bruit	<input type="checkbox"/> Strong	<input type="checkbox"/> Adequate	<input type="checkbox"/> Poor	<input type="checkbox"/> Absent
	<input type="checkbox"/> High Pitched	<input type="checkbox"/> Low Pitched		
Thrill	<input type="checkbox"/> Strong	<input type="checkbox"/> Weak	<input type="checkbox"/> Absent	<input type="checkbox"/> Pulsatile
Hand/Foot Temp	<input type="checkbox"/> Hot	<input type="checkbox"/> Warm	<input type="checkbox"/> Cool	<input type="checkbox"/> Cold
Hand/Foot Colour	<input type="checkbox"/> Normal	<input type="checkbox"/> Red	<input type="checkbox"/> Dusky	<input type="checkbox"/> Blue
Finger/Toe Capillary Refill	<input type="checkbox"/> Delayed	<input type="checkbox"/> Normal		
Pain	<input type="checkbox"/> Not Present	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
	<input type="checkbox"/> Normal	<input type="checkbox"/> Tight	<input type="checkbox"/> Shiny	<input type="checkbox"/> Tender
Skin Integrity	<input type="checkbox"/> Edematous	<input type="checkbox"/> Breakdown		
	<input type="checkbox"/> Soft	<input type="checkbox"/> Easily compressible	<input type="checkbox"/> Easily palpable	<input type="checkbox"/> Poorly palpable
Vessel Condition	<input type="checkbox"/> Mild bulging	<input type="checkbox"/> Moderate bulging	<input type="checkbox"/> Collateral development	<input type="checkbox"/> Normal
Vein diameter	_____ mm			
Vein depth	_____ mm			
Is patient exercising access arm?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	

**Summary of Findings:**

Maturing as expected for age/stage of access

Maturing but concerns identified

Not maturing as expected for age/stage of access

**If maturing but concerns identified, or not maturing, please complete the next two sections:**

Comments re concerns:

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**Potential Conditions:**

- Collateral vessels developing
- Failure to mature
- Needs more time to assess
- Poor arterial supply
- Possible steal syndrome
- Possible stenosis
- Possible thrombosis
- Possible infection
- Swollen
- Other, please specify \_\_\_\_\_

**Plan:**

- Continue regular follow-up
- Repeat assessment in 1 – 2 weeks
- Further investigation needed
- Refer to Nephrologist for assessment and/or antibiotics
- Refer to Surgeon for assessment
- Refer to VA Clinic for assessment

**Investigations Required:**

- |   |                                     |                                    |
|---|-------------------------------------|------------------------------------|
| <input type="checkbox"/> Arteriogram                  | <input type="checkbox"/> Unilateral | <input type="checkbox"/> Bilateral |
|   | <input type="checkbox"/> Arm        | <input type="checkbox"/> Leg       |
|   | <input type="checkbox"/> Right      | <input type="checkbox"/> Left      |
| <input type="checkbox"/> Venogram                     | <input type="checkbox"/> Unilateral | <input type="checkbox"/> Bilateral |
|   | <input type="checkbox"/> Arm        | <input type="checkbox"/> Leg       |
|   | <input type="checkbox"/> Right      | <input type="checkbox"/> Left      |
| <input type="checkbox"/> CT Scan                      |                                     |                                    |
| <input type="checkbox"/> Doppler Ultrasound           |                                     |                                    |
| <input type="checkbox"/> Fistulogram                  |                                     |                                    |
| <input type="checkbox"/> Fistulogram +/- Angioplasty  |                                     |                                    |
| <input type="checkbox"/> Other (please specify) _____ |                                     |                                    |

**Additional Notes:**

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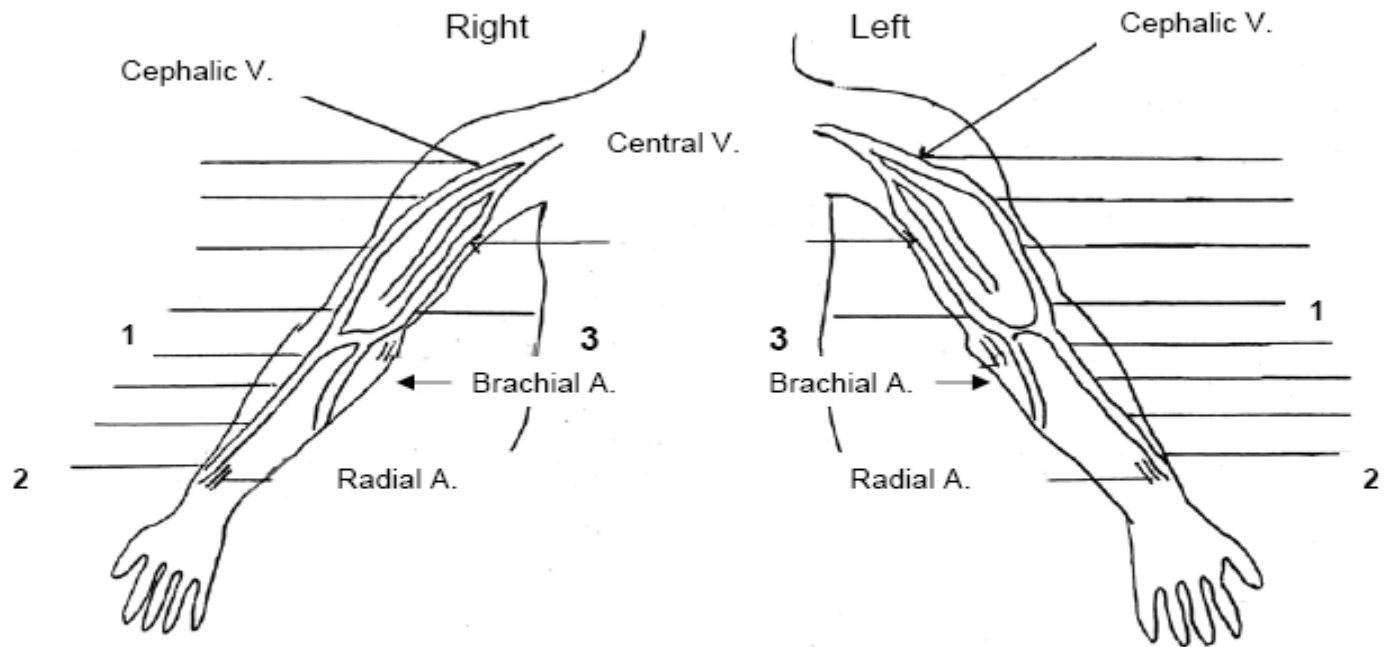
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**Assessed by:** \_\_\_\_\_

**Location assessment completed:** \_\_\_\_\_

**Next appointment date (if applicable):** \_\_\_\_\_

# Vascular Access Mapping



COMMENTS:

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