

Add Health Authority Logo

Add Name & Address of Vascular Access Clinic

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):

Side:	Left	Right	Location:	Fistula	Graft	AVG Only:	
	<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"/>		

Assessment	Findings			
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 <input type="checkbox"/> White
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:

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) _____ | | |

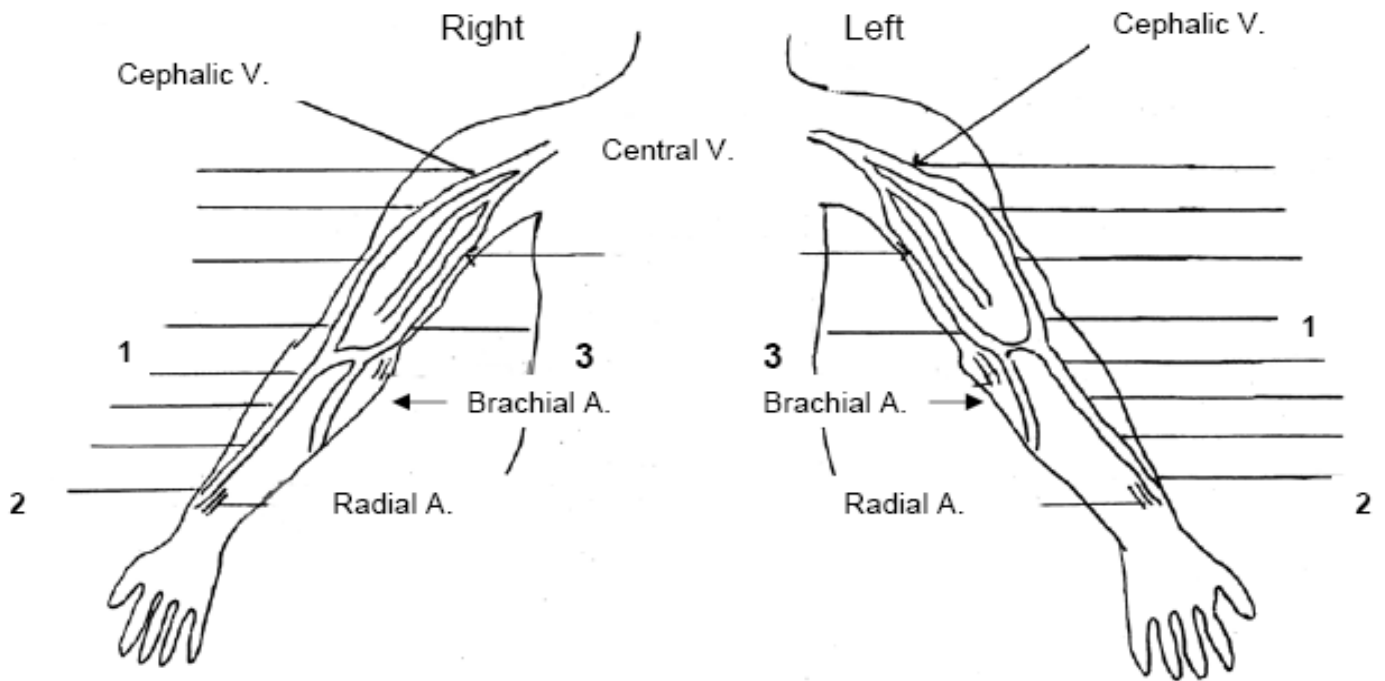
Additional Notes:

Assessed by: _____

Location assessment completed: _____

Next appointment date (if applicable): _____

Vascular Access Mapping



COMMENTS:
