



Right

Left

SURGEON:
Please indicate the direction of the arterial and venous blood flow.

Hemodialysis Arteriovenous Fistula (AVF)

Patient: _____
Date Created: _____
Hospital: _____
Surgeon: _____

Please Fax this to

- Dialysis Facility: # _____
- Nephrologist: # _____

AVF Type

- Radial-Cephalic
- Brachial Cephalic
- Proximal Radial Artery
- Transposition: _____

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Surgeons Instructions/ Comments

The patient should return to see the surgeon for post-op appointments in 7-14 days, 3-4 weeks, and 2-3 months - or as specially indicated.