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**Case Documentation Checklist**

**Superficial Venous/Vein Center**

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| **Pre-Procedure Documentation**[ ]  Complete patient history and physical exam documentation, including, but not limited to: * History of venous disorders
* Past medical history
* Family history
* Current medications
* Allergies
* Appropriate clinical indication for the procedure

[ ]  Noninvasive diagnostic functional reflux ultrasound final report and images (if indicated).[ ]  VCSS score (bilateral)[ ]  CEAP (bilateral)[ ]  QoL measure[ ]  Treatment plan | **Procedure****Documentation**[ ]  Procedure, limb and vessel-specific informed consent[ ]  Complete venous procedure summary, including but not limited to:* Documentation of correct patient, site, and procedure
* Anesthesia record
* Concentration/amount of tumescent infused
* Local anesthetic (if used)
* Treatment sites
* Start/end time of procedure.
* Length of vessel treated.
* Catheter insertion site
* Energy deposited/RF cycles.
* Number of stabs (AP)
* Complications or lack thereof
* Patient status post procedure
 | **Post-Procedure Documentation**[ ]  Discharge instructions including:* Procedure performed
* Post-procedure care and expectations
* Possible adverse events or complications which may require contact with a health care provider
* Contact information to access the health care team
* Dressing management including compression therapy.
* Patient activity, ambulation and exercise
* Air and car travel restrictions
* Medications
* Follow-up appointments

**Follow-Up Documentation**:[ ]  Follow-up clinical notes[ ]  Follow-up diagnostic ultrasound report |

**Peripheral Arterial/Deep Venous/Hemodialysis Access**

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| **Pre-Procedure Documentation**[ ]  Complete patient history and physical exam documentation, including, but not limited to: * Chief complaint
* Past medical history
* Family history
* Current medications
* Allergies
* Indication for the procedure
* Symptoms and treatment history
* Anticoagulation and treatment duration
* QoL measure
* Treatment plan
* CEAP (deep venous)
* VCSS (deep venous)

[ ]  Imaging/consultations[ ]  Mallampati (if sedated)[ ]  ASA score (if sedated)[ ]  Lab studies | **Procedure** **Documentation**[ ]  Procedure specific informed consent[ ]  Complete procedure summary, including but not limited to:* Documentation of correct patient, site, and procedure
* Indication for procedure
* Description of procedure
* Structures imaged.
* Operative findings
* Treatment performed: success/inadequacy
* Complications
* Sedation records
* Devices used
* Documentation of skin preparation and drape
* Access site
* Medications used
* Fluoroscopy exposure
* EBL
* Contrast type and volume
* Patient status at end of procedure
* name of person performing procedure
* surgical assistant and/or circulator
* procedure start and end time
* anticoagulation
 | **Post-Procedure Documentation**[ ]  Discharge instructions including:* Procedure performed
* Management of post-procedure pain
* Anticoagulation or antiplatelet therapy
* Access site, dressings, and wound care
* Compression instructions
* Bathing instructions
* Patient activity
* Air and car travel restrictions
* adverse events or complications
* contact information for health care team.
* Follow-up appointments

**Follow-Up Documentation**:[ ]  Follow-up clinical notes[ ]  Follow-up imaging reports |