Vascular Surgery Follow-Up

	30 Day Follow-Up	1 Year Follow-Up
Contact Date	_____/_____/_____	_____/_____/_____
Ambulation	o Independent o Wheelchair o Bedridden o Ambulances with assistance o Not documented	o Independent o Wheelchair o Bedridden o Ambulances with assistance o Not documented
Current Living Status	o Home o Dead o Nursing Home/Extended Care o Date of Death____/_____/_____ o Assisted Living o Cause of Death o In Hospital o Cardiovascular o Not documented o Operation Related o Unknown/ Other	o Home o Dead o Nursing Home/Extended Care o Date of Death____/_____/_____ o Assisted Living o Cause of Death o In Hospital o Cardiovascular o Not documented o Operation Related o Unknown/ Other
Readmission to Hospital **Date**: _____/_____/_____	☐ Yes ☐ No ☐Not Doc o Lymph leak (seroma) o Anticoagulation complication o Wound infection /dehiscence o Thrombectomy/lysis o Graft infection o Other	☐ Yes ☐ No ☐ Not Doc o Lymph leak (seroma) o Anticoagulation complication o Wound infection /dehiscence o Thrombectomy/lysis o Graft infection o Other
Smoking	☐ Yes ☐ No ☐ Not documented	☐ Yes ☐ No ☐ Not documented
Antiplatelets	☐ Yes ☐ No ☐ Not documented ☐ Contraindicated	☐ Yes ☐ No ☐ Not documented ☐Contraindicated
Statin	☐ Yes ☐ No ☐ Not documented ☐ Contraindicated	☐ Yes ☐ No ☐ Not documented ☐Contraindicated
Aspirin	☐ Yes ☐ No ☐ Not documented ☐ Contraindicated	☐ Yes ☐ No ☐ Not documented ☐Contraindicated
Beta Blocker	☐ Yes ☐ No ☐ Not documented ☐ Contraindicated	☐ Yes ☐ No ☐ Not documented ☐Contraindicated
ACE Inhibitor	☐ Yes ☐ No ☐ Not documented ☐ Contraindicated	☐ Yes ☐ No ☐ Not documented ☐Contraindicated
Anticoagulant	☐ Yes ☐ No ☐ Not documented	☐ Yes ☐ No ☐ Not documented
ARBs	☐ Yes ☐ No ☐ Not documented	☐ Yes ☐ No ☐ Not documented
Other Cholesterol Lowering Agents	☐ Yes ☐ No ☐ Not documented	☐ Yes ☐ No ☐ Not documented
Procedure Type:	**Select from below if applicable**	**Select from below if applicable**
Open AAA Subsequent Operations **Date**: _____/_____/_____	☐ Incision ☐ Graft ☐ Intestine ☐ Leg Ischemia	☐ Incision ☐ Graft ☐ Intestine ☐ Leg Ischemia
EVAR Imaging Performed	Date _____/_____/_____	Date _____/_____/_____
EVAR Current AAA Diameter	_____mm	_____mm
EVAR Current Endoleak	☐ Yes ☐ No ○ Type 1 ○ Type 2 ○ Type 3 ○ Indeterminate	☐ Yes ☐ No ○ Type 1 ○ Type 2 ○ Type 3 ○ Indeterminate
EVAR Additional Procedure **Date**: _____/_____/_____	☐ Yes ☐ No ☐ Endoleak ☐ Migration ☐ Sac Growth ☐ Limb Occlusion ☐ Symptoms-Rupture	☐ Yes ☐ No ☐ Endoleak ☐ Migration ☐ Sac Growth ☐ Limb Occlusion ☐ Symptoms-Rupture
EVAR Conversion to Open **Date**: _____/_____/_____	☐ Yes ☐ No ☐ Endoleak ☐ Migration ☐ Sac Growth ☐ Limb Occlusion ☐ Symptoms-Rupture	☐ Yes ☐ No ☐ Endoleak ☐ Migration ☐ Sac Growth ☐ Limb Occlusion ☐ Symptoms-Rupture
Open Bypass ABIs	☐ Yes ☐ No ○ Right ABI value_____ ○ Left ABI value_____	☐ Yes ☐ No ○ Right ABI value_____ ○ Left ABI value_____
Open Bypass TBIs	☐ Yes ☐ No ○ Right TBI value_____ ○ Left TBI value_____	☐ Yes ☐ No ○ Right TBI value_____ ○ Left TBI value_____
Open Bypass Toe Pressure	☐ Yes ☐ No ○ Right Toe value_____ ○ Left Toe value_____	☐ Yes ☐ No ○ Right Toe value_____ ○ Left Toe value_____
Open Bypass Revision	☐ Surgical ☐ Percutaneous **Date**: _____/_____/_____	☐ Surgical ☐ Percutaneous **Date**: _____/_____/_____
Open Bypass Patency	Open Bypass Patent: Y / N	Open Bypass Patent: Y / N
Open Bypass Pulses	o Palpable graft pulse o ABI increase >0.15 o Palpable distal pulse o Duplex	o Palpable graft pulse o ABI increase >0.15 o Palpable distal pulse o Duplex
Open Thromb Repeat Proc	☐ Surgical ☐ Percutaneous Date _____/_____/_____ Date _____/_____/_____	☐ Surgical ☐ Percutaneous Date _____/_____/_____ Date _____/_____/_____
Open Thromb Add'l Proc	☐ Surgical ☐ Percutaneous Date _____/_____/_____ Date _____/_____/_____	☐ Surgical ☐ Percutaneous Date _____/_____/_____ Date _____/_____/_____
Open Thromb Patent	o Yes o No	o Yes o No
Wound Complication	☐ Yes ☐ No ☐ Not documented Date: ____/____/____	☐ Yes ☐ No ☐ Not documented Date: ____/____/____
Amputation ☐ Yes ☐ No ☐Not Documented Date: _____/_____/_____	○ Left AKA ○ Left BKA ○ Right AKA ○ Right BKA ○ Left foot ○ Right foot ○ Left metatarsal ○ Right metatarsal ○ Left Digit ○ Right Digit ○ Left Hip Disarticulation ○ Right Hip Disarticulation	○ Left AKA ○ Left BKA ○ Right AKA ○ Right BKA ○ Left foot ○ Right foot ○ Left metatarsal ○ Right metatarsal ○ Left Digit ○ Right Digit ○ Left Hip Disarticulation ○ Right Hip Disarticulation
MI	☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____	☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____
TIA/Stroke	☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____	☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____

Renal Failure/Dialysis	**30 day Follow-Up ONLY** ☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____
Transfusion	**30 day Follow-Up ONLY** ☐ Yes ☐ No ☐ Not documented Date: _____/_____/_____
Still Taking Opioid	**30 day Follow-Up ONLY** ☐ No ☐Same as discharge ☐ New opioid/dose
Type of Opioid	☐ Hydrocodone (Norco, Vicodin, Lortab, Lorcet) ☐ Oxycodonoe (OxyContin, Percocet, Roxicodone) ☐ Codeine (Tylenol 2, 3,or 4) ☐ Tramadol (Ultram, Ultram ER) ☐ Other (Fentanyl, Morphine, Hydromorphone, Dilaudid, Methadone, etc)
Opioid 1 Dose/Unit	_____ ☐ mg ☐ ml ☐ mcg/hr ☐ mg/ml ☐ mcg/ml ☐ other
Opioid 2 Dose/Unit	_____ ☐ mg ☐ ml ☐ mcg/hr ☐ mg/ml ☐ mcg/ml ☐ other
Prescribing Provider	☐ Procedural physician/surgeon ☐ Primary care physician ☐ Other surgical physician ☐ Pain specialist ☐ Oncologist ☐ Other
Refills Requested	☐ Yes ☐ No **Refills given** ☐ Yes ☐ No
Prescribing Provider	☐ Procedural physician/surgeon ☐ Primary care physician ☐ Other surgical physician ☐ Pain specialist ☐ Oncologist ☐ Other