



PATIENT SELECTION  
PRE-OPERATIVE CHECKLIST

Procedure Date: \_\_\_\_\_

Physician: \_\_\_\_\_ Facility: \_\_\_\_\_

Case Manager/Non-Physician Contact: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient ID Details: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Weight/kg: \_\_\_\_\_ Height: \_\_\_\_\_

Reason Access (CVA) Required: \_\_\_\_\_ Is this life saving:  YES  NO

Dialysis  Other: (If other please note): \_\_\_\_\_

Is imaging available, **less than one month old**, that clearly shows the location, and extent, of the occlusion; and allows the questions below to be answered?

**IMAGING:** Contrast enhanced coronial, sagittal, and axial CT venogram head to pelvis. Less than 1 month old.

- Need clear patency from right femoral vein to superior vena cava
- Predefine pattern of any obstruction or clinical signs of acute thrombus
- Show location and extent of occlusion

- NO → DO NOT PROCEED WITH CASE
- YES → What type of imaging is available:
- \_\_\_\_\_

	YES	NO
Foreign material within occlusion or vasculature to be traversed by device: (Eg: pacing leads, grafts, stents, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Vascular tortuosity:	<input type="checkbox"/>	<input type="checkbox"/>
Excessive spinal curvature: (eg: scoliosis, lordosis or kyphosis)	<input type="checkbox"/>	<input type="checkbox"/>
Previous thoracic or abdominal surgery:	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to contrast medium: If yes, what is the operative plan? _____ <small>*Contrast is required for this procedure.</small>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired coagulation: Including medically induced	<input type="checkbox"/>	<input type="checkbox"/>
Any other anomalies/concerns: Medical history review recommended	<input type="checkbox"/>	<input type="checkbox"/>

Give further details if any of the above questions were answered: **YES**  
**It is recommended that further advice is obtained from BVT and Merit Medical. Please see IFU0002 for further details.**

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\_\_\_\_\_

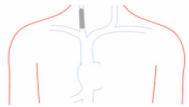
\_\_\_\_\_

\_\_\_\_\_

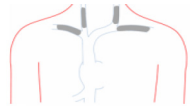
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\_\_\_\_\_

Classification of Occlusion (Please indicate the appropriate image)



Type 1. Unilateral RIJ occlusion



Type 2. Bilateral IJ and SC occlusions



Type 3. SVC occlusion above azygos



Type 4. Total occlusion of SVC

	YES	NO
SVC / Atrial Junction clearly visible:	<input type="checkbox"/>	<input type="checkbox"/>
All Limbs Present: If no, which limbs are not present? _____	<input type="checkbox"/>	<input type="checkbox"/>
IVC, Right Femoral and Right Iliac veins patent: If not patent, what is the preoperative/operative plan? _____ If yes, which vessels are occluded? _____	<input type="checkbox"/>	<input type="checkbox"/>
Femoral Catheter Present? If yes, which limb? _____	<input type="checkbox"/>	<input type="checkbox"/>
Patient anatomy or body habitus inhibiting access to the right femoral vein, or right supraclavicular space? (Large panus, neck folds, infection, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Give further details if any of the above questions were answered: **NO**

**It is recommended that further advice is obtained from BVT and Merit Medical. Please see IFU0002 for further details.**

Further Details/Comment:

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Operative Plan:

Was this discussed/agreed at a Multi-Team meeting:  YES  NO

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Future Treatments if Applicable:

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SUPPLIED BY:



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Please forward all relevant information and queries to [Surfacer@merit.com](mailto:Surfacer@merit.com).