Supplemental Digital Content Figure 2. Venous Access Record Data Collection
(adapted from Baskin, et al. 2019)[25]

1. Patient History
    a. Diagnosis requiring central venous access
    b. Additional diagnoses
    c. Contraindications/Complicating factors
        i. Coagulopathy
        ii. Thrombophilia
        iii. Immunodeficiency
        iv. Small intestinal bacterial overgrowth
2. Referring physician for central venous access
3. Indication for central venous access
4. Most recent vascular/catheter imaging (ultrasonography, venogram, chest radiograph)
5. Anticipated duration of central access
6. Who placed current central venous access (institution and group – surgery vs. interventional radiology)
7. Pre-/Periprocedural interventions (antibiotics, blood products, etc.)
8. Procedure complications
9. Location of central access (side and site, imaging used, route, number of attempts)
10. Catheter tip location
11. Catheter information (manufacturer, lumen number, diameter, final catheter length, cuff)
12. Catheter locks (ethanol, antibiotic, heparin)
13. Catheter complications
    a. Catheter-related infection – total number (per 1,000 catheter days), date, type (central line-associated blood stream infection, site infection, tunnel infection, etc.), culture results, management (antibiotic, line removal), outcome
    b. Catheter dysfunction – date, type (infiltration/extravasation, line occlusion, line break, fibrin sheath, tip thrombus, etc.), management, outcome
    c. Vein complications – date, type (stenosis, thrombosis, fibrosis, occlusion), imaging, location/extent, related symptoms, management, outcome
    d. Catheter position – date, type (dislodgment, migration, malposition), management, outcome
    e. Other catheter-related complications (superior vena cava syndrome, post thrombotic syndrome, etc.)
14. Removal, replacement, or other intervention – date, reason