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ANTICOAGULATION MANAGEMENT (ACM) and THROMBOSIS CLINIC REFERRAL

Jim Pattison Outpatient Care and Surgery Centre

Form ID: MSXX104191G Rev: July 16, 2020 Page: 1 of 2

9750 140 St. Surrey BC V3T 0G9 ☎ **604-582-4550 ext 763869** 🖷 **604-528-5435**

Patient's Full Name: _____ (First / Middle Initial / Last)

Other Name(s): _____ Gender: M ☐ F ☐ Non-binary ☐

Personal Health Number: _____ Date of Birth: _____ (DD/MM/YYYY)

Address: _____ (Street / City / Province / Postal Code)

Phone: _____ (Home / Mobile) ☐ Okay to Leave Message

Alternate Contact: _____ (Name / Phone No) Interpreter? ☐ YES Language: _____

Insurance (if non-MSP): _____ Isolation Precautions: Airborne ☐ Contact ☐ Droplet ☐

Reason for Referral: _____

SERVICES REQUESTED

ANTICOAGULATION MANAGEMENT (ACM) CLINIC:

- ☐ Initial anticoagulation selection and duration (Specify indication on page 2)
- ☐ Pharmacist led management and education on oral anticoagulant and LMWH
- ☐ Patients initiated on anticoagulation requiring close monitoring for bleed and thrombosis recurrence

☐ **Please sign below and complete page 2**

Patients will be seen within 24-48 hours

This referral form, when completed, is a medical referral to a medical consultant of the Anticoagulation Management (ACM) Clinic. Signing this form authorizes the ACM Clinic to order and check laboratory tests pertaining to anticoagulation, order anticoagulants, adjust warfarin to achieve target INRs, to use oral Vitamin K for reversing warfarin therapy, and to implement subcutaneous low molecular weight heparin bridging therapy when appropriate. (see ACM Clinic Scope of Responsibility)

Referring Provider Signature: _____

THROMBOSIS CLINIC:

Physician consultation for:

- ☐ Long-term anticoagulation selection and duration
- ☐ Anticoagulation recommendations in medically complex patients and patients with unprovoked VTE
- ☐ Assessment for secondary workup
- ☐ Patients with IVC filter
- ☐ Assessment for indication(s) for anticoagulation bridging in patients with previous VTE

Referral Priority:

☐ Non-urgent > 3 months ☐ Less-urgent < 4 weeks

☐ Urgent: contact Hematologist on call

Medical Reason for Urgency:

_____

MEDICAL HISTORY: *(or attach medical record)*	**CURRENT MEDICATIONS:** *(or attach medication list)*

Referrals must include referral letter, relevant imaging and most recent blood work (CBC, renal and liver function)

REFERRING HEALTH CARE PROVIDER	**FOR CLINIC USE ONLY**
Name: _____ MSP: _____	Date: _____ ☐ IM
Phone: _____ Fax: _____	☐ Heme ☐ ACM
Date: _____ Title: _____	☐ Additional Information Requested
Family Physician: (if different) _____	Urgency: _____

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Page 2 only needs to be completed for Anticoagulation Management Clinic Referral

INDICATION(S) FOR INITIATION OF ANTICOAGULATION THERAPY:
☐ Deep Vein Thrombosis ☐ Pulmonary Embolus ☐ Thrombosis (Other)
☐ Atrial Fibrillation or Valvular Heart Disease: Reserved to help facilitate hospital discharge for patients requiring INR monitoring while their family physician is temporarily unavailable. ACM will consider acceptance of referral on case by case basis, for short-term monitoring only. **Instructions to Central Intake/Unit Clerk: MUST confirm referral acceptance with ACM prior to booking**
TARGET INR RANGE:
☐ 2-3 ☐ 2.5-3.5 ☐ Other, please specify:
DURATION OF THERAPY:
☐ 3 months ☐ Indefinite ☐ To be suggested by ACM ☐ Other, please specify:
ANTICOAGULATION:
☐ Low Molecular Weight Heparin ☐ Warfarin ☐ Other, please specify: _____ ☐ Warfarin and Low Molecular Weight Heparin (i.e. bridging therapy until INR therapeutic) **Warfarin Start Date:** _____ **Dose(s) Already Given:** _____

Date						
Dose						