

Date:	<b>Clot Assist VTE Outpatient Antithrombotic Therapy Requisition</b> <b>drug + bean, mission pharmacy, suite #120, 2210 2<sup>nd</sup> St. S.W</b> <b>Phone: 587.356.3786 Fax: 587.356.3787</b> <b>If referring a patient outside of operating hours, please phone Steve at 587-891-8808 or Shaheena at 647-949-8507 to confirm receipt of form.</b>
Time:	

**Patient Information and/or Label:**  
Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ PHN: \_\_\_\_\_

**Ordering Physician Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_ **Contact #:** \_\_\_\_\_  
**Most Responsible Physician Name:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_ **Contact #:** \_\_\_\_\_  
**Pharmacy to fax summary to:**  Medical Oncology 403-283-1651  BMT 403-521-3644  Hematology 403-521-3799  
Other: \_\_\_\_\_

**Confirmation of DVT/PE:**

<input type="checkbox"/> Lower extremity DVT	<input type="checkbox"/> PE
<input type="checkbox"/> Upper extremity DVT: (brachial, axillary, or more proximal vein involvement)	<input type="checkbox"/> Unusual site thrombosis: (brachial vein, splanchnic vein, cerebral vein, etc.)

**Clotting and Bleeding Risk Information: Please proceed with therapy**

<input type="checkbox"/> Type of Cancer:	<input type="checkbox"/> Angiogenesis inhibitors: (Bevacizumab, thalidomide, lenalidomide, sutent)
<input type="checkbox"/> Biological response modifiers (e.g. inteferon, rituximab, trastuzumab, tamoxifen)	<input type="checkbox"/> Nonspecific immunomodulating agents: (e.g. 5-florouracil, cisplatin, etc)
<input type="checkbox"/> L-asparaginase	<input type="checkbox"/> Recent major bleeding.
<input type="checkbox"/> Clotting disorder:	<input type="checkbox"/> Bleeding disorder:

**Treat with LMWH in conjunction with current antiplatelet therapy:**

<input type="checkbox"/> ASA	<input type="checkbox"/> Clopidogrel	<input type="checkbox"/> Prasugrel
<input type="checkbox"/> Ibuprofen/NSAID	<input type="checkbox"/> Ticagrelor	<input type="checkbox"/>

**Discontinue current oral anticoagulant therapy (Warfarin, dabigatran, rivaroxaban, apixaban, etc.):**  
Drug Name & Dose: \_\_\_\_\_ Reason for drug: \_\_\_\_\_  
Date and time last taken: \_\_\_\_\_ Most recent INR date: \_\_\_\_\_

Yes  No Please proceed if CrCl, platelets, or RBCs are up to 6 months old, **as this patient is not currently receiving any therapy that would affect these values.** The pharmacist will prescribe LMWH, give the patient lab work to measure CBC and CrCl immediately, and if necessary adjust dose once lab work is completed.

**Pharmacist will weigh patient, check Hb, PLT, Leukocytes, calculated CrCl, prescribe LMWH and screen for HIT. Most responsible physician (MRP) must follow up with patient, ideally within two weeks.**  
Prescription duration:  30 days  3 months  6 months  Other \_\_\_\_\_  
If desired, specify: LMWH \_\_\_\_\_ Special dosing instructions: \_\_\_\_\_

Fax to 587.356.3787 drug + bean, mission pharmacy, suite #120, 2210 2<sup>nd</sup> St. S.W., Calgary

The documents accompanying this facsimile contain confidential information that may be legally privileged and protected by Federal and Provincial law. This information is intended for use only by the entity or individual to whom it is addressed. The authorized recipient is obligated to maintain the information in a safe, secure, and confidential manner. If you are in possession of this protected health information, and are not the intended recipient, you are hereby notified that any improper disclosure, copying, or distribution of the contents of this information is strictly prohibited. Please notify the owner of this information immediately and arrange for its return or destruction.