Date:	**Clot Assist VTE Outpatient Antithrombotic Therapy Requisition**
Time:	**drug + bean, mission pharmacy,** suite #120, 2210 2nd St. S.W **Phone: 587 356.3786 Fax: 587.356.3787** **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.**

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:

Lower extremity DVT	☐ PE
☐ Upper extremity DVT: (brachial, axillary, or more proximal vein involvement)	☐ Unusual site thrombosis: (brachial vein, splanchnic vein, cerebral vein, etc.)

Clotting and Bleeding Risk Information: Please proceed with therapy

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

Treat with LMWH in conjunction with current antiplatelet therapy:

☐ ASA	☐ Clopidogrel	☐ Prasugrel
☐ Ibuprofen/NSAID	☐ Ticagrelor	☐

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:_____

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