Date:	**Clot Assist VTE Outpatient Antithrombotic Requisition** **Shoppers Drug Mart #326,** Bower Place Mall, 4900 28 St, Unit #1043 **Phone: 403.343.3355 Fax: 403.343.6622**
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 403.346.1160 Medical Oncology phone: 403.314.6974**

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, calculate 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 403.343.6622 – Shoppers Drug Mart #326, Bower Place Mall, 4900, 28th St, Unit 1043, Red Deer, AB