

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: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Lower extremity DVT </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> PE </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Upper extremity DVT: (brachial, axillary, or more proximal vein involvement) </td> <td style="vertical-align: top;"> <input type="checkbox"/> Unusual site thrombosis: (brachial vein, splanchnic vein, cerebral vein, etc.) </td> </tr> </table>				<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.)				
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Clotting and Bleeding Risk Information: Please proceed with therapy <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Type of Cancer: </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Angiogenesis inhibitors: (Bevacizumab, thalidomide, lenalidomide, sutent) </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Biological response modifiers (e.g. inteferon, rituximab, trastuzumab, tamoxifen) </td> <td style="vertical-align: top;"> <input type="checkbox"/> Nonspecific immunomodulating agents: (e.g. 5-florouracil, cisplatin, etc) </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> L-asparaginase </td> <td style="vertical-align: top;"> <input type="checkbox"/> Recent major bleeding. </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Clotting disorder: </td> <td style="vertical-align: top;"> <input type="checkbox"/> Bleeding disorder: </td> </tr> </table>				<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:
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Treat with LMWH in conjunction with current antiplatelet therapy: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> ASA </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Clopidogrel </td> <td style="width: 33%; vertical-align: top;"> <input type="checkbox"/> Prasugrel </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> Ibuprofen/NSAID </td> <td style="vertical-align: top;"> <input type="checkbox"/> Ticagrelor </td> <td style="vertical-align: top;"> <input type="checkbox"/> </td> </tr> </table>				<input type="checkbox"/> ASA	<input type="checkbox"/> Clopidogrel	<input type="checkbox"/> Prasugrel	<input type="checkbox"/> Ibuprofen/NSAID	<input type="checkbox"/> Ticagrelor	<input type="checkbox"/>		
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Discontinue current oral anticoagulant therapy (Warfarin, dabigatran, rivaroxaban, apixaban, etc.): <input type="checkbox"/> Drug Name & Dose: _____ Reason for drug: _____ <input type="checkbox"/> Date and time last taken: _____ Most recent INR date: _____											
<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 30 days <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 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 <small>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.</small>											