

Date:	Clot Assist Requisition Medicine Shoppe #127, 1016A – 20 Street South, Lethbridge Phone: 403.380 3282 Fax: 403.380.3426 Vishal Sukhadiya cell: 403 715 0021 Available 24 hrs
Time:	

Patient Information and/or Label:
Name: _____ DOB: _____ Cell Phone: _____
Address: _____ PHN: _____

Referring Physician Name: _____ Specialty: _____ Contact #: _____

Most Responsible Physician Name: _____ Contact #: _____ Fax #: _____

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, 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 403.380.3426 – The Medicine Shoppe Pharmacy #127, 1016A – 20 Street South, Lethbridge, AB T1K 2C9

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