



fraserhealth

ANTICOAGULATION MANAGEMENT (ACM) and THROMBOSIS CLINIC REFERRAL

Jim Pattison Outpatient Care and Surgery Centre



Form ID: MSXX104191G

Rev: July 16, 2020

Page: 1 of 2

9750 140 St. Surrey BC V3T 0G9

☎ 604-582-4550 ext 763869

☎ 604-528-5435

Patient's Full Name: _____
First Middle Initial Last

Other Name(s): _____ Gender: M F Non-binary

Personal Health Number: _____ Date of Birth: _____
DD/MM/YYYY

Address: _____
Street City Province Postal Code

Phone: _____ Okay to Leave Message
Home Mobile

Alternate Contact: _____ Interpreter? YES Language: _____
Name Phone No

Insurance (if non-MSP): _____ Isolation Precautions: Airborne Contact Droplet

Reason for Referral: _____

SERVICES REQUESTED

ANTICOAGULATION MANAGEMENT (ACM) CLINIC:

- Initial anticoagulation selection and duration (Specify indication on page 2)
- Pharmacist led management and education on oral anticoagulant and LMWH
- Patients initiated on anticoagulation requiring close monitoring for bleed and thrombosis recurrence

Please sign below and complete page 2

Patients will be seen within 24-48 hours

This referral form, when completed, is a medical referral to a medical consultant of the Anticoagulation Management (ACM) Clinic. Signing this form authorizes the ACM Clinic to order and check laboratory tests pertaining to anticoagulation, order anticoagulants, adjust warfarin to achieve target INRs, to use oral Vitamin K for reversing warfarin therapy, and to implement subcutaneous low molecular weight heparin bridging therapy when appropriate. (see ACM Clinic Scope of Responsibility)

Referring Provider Signature: _____

THROMBOSIS CLINIC:

Physician consultation for:

- Long-term anticoagulation selection and duration
- Anticoagulation recommendations in medically complex patients and patients with unprovoked VTE
- Assessment for secondary workup
- Patients with IVC filter
- Assessment for indication(s) for anticoagulation bridging in patients with previous VTE

Referral Priority:

- Non-urgent > 3 months Less-urgent < 4 weeks
- Urgent: contact Hematologist on call

Medical Reason for Urgency: _____

MEDICAL HISTORY: (or attach medical record)

CURRENT MEDICATIONS: (or attach medication list)

Referrals must include referral letter, relevant imaging and most recent blood work (CBC, renal and liver function)

REFERRING HEALTH CARE PROVIDER

Name: _____ MSP: _____
 Phone: _____ Fax: _____
 Date: _____ Title: _____
 Family Physician: (if different) _____

FOR CLINIC USE ONLY

Date: _____ IM
 Heme ACM
 Additional Information Requested
 Urgency: _____



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Page 2 only needs to be completed for Anticoagulation Management Clinic Referral

INDICATION(S) FOR INITIATION OF ANTICOAGULATION THERAPY:						
<input type="checkbox"/> Deep Vein Thrombosis <input type="checkbox"/> Pulmonary Embolus <input type="checkbox"/> Thrombosis (Other)						
<input type="checkbox"/> Atrial Fibrillation or Valvular Heart Disease: Reserved to help facilitate hospital discharge for patients requiring INR monitoring while their family physician is temporarily unavailable. ACM will consider acceptance of referral on case by case basis, for short-term monitoring only. Instructions to Central Intake/Unit Clerk: MUST confirm referral acceptance with ACM prior to booking						
TARGET INR RANGE:						
<input type="checkbox"/> 2-3 <input type="checkbox"/> 2.5-3.5 <input type="checkbox"/> Other, please specify:						
DURATION OF THERAPY:						
<input type="checkbox"/> 3 months <input type="checkbox"/> Indefinite <input type="checkbox"/> To be suggested by ACM <input type="checkbox"/> Other, please specify:						
ANTICOAGULATION:						
<input type="checkbox"/> Low Molecular Weight Heparin <input type="checkbox"/> Warfarin <input type="checkbox"/> Other, please specify: _____						
<input type="checkbox"/> Warfarin and Low Molecular Weight Heparin (i.e. bridging therapy until INR therapeutic)						
Warfarin Start Date: _____ Dose(s) Already Given: _____						
Date						
Dose						

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