Thrombosis Program
Vancouver Coastal Health, University of British Columbia

VGH Thrombosis Clinic
Blackmore Pavilion, 6th Floor
855 West 12th Avenue
Vancouver, BC V5Z 1M9

Tel: 604.675.2481
Fax: 604.875.5071

VGH Thrombosis Clinic
Acute VTE Referral Form (BC Cancer Vancouver Centre)

Please provide the following information and fax the complete form to **604-875-5071**. Incomplete referral forms will delay triaging. An appointment will be arranged for the next weekday.

Patient Information *(on BC Health Card)*

Last Name: _____ First Name: _____ PHN: _____

DOB: _____ Contact Tel: _____ Email: _____
dd-mmm-yyyy

Referring Oncologist

Last Name: _____ First Name: _____ MSP #: _____

Site of Acute VTE: *Please select the most appropriate reason.*

- ◯ Proximal leg DVT *(common femoral, femoral, popliteal vein)*
- ◯ Distal leg DVT *(posterior tibial, anterior tibial, peroneal vein)*
- ◯ Pulmonary embolism
- ◯ Upper extremity DVT *(jugular, subclavian, axillary, brachial)*
- ◯ High risk superficial thrombophlebitis *(thrombus longer than 5 cm or proximal end of thrombus within 3 cm of junction with a deep vein)*
- ◯ Central venous catheter-related thrombosis
- ◯ Splanchnic vein thrombosis *(e.g., portal, mesenteric, splenic)*
- ◯ Other: _____

Date of VTE Diagnosis: _____
dd-mmm-yyyy

Diagnostic Imaging: *Check the imaging study that confirmed VTE.*

- ◯ Ultrasound
- ◯ CT scan *(regular contrast CT)*
- ◯ CTPA *(CT pulmonary embolism protocol)*
- ◯ VQ lung scan
- ◯ MRI
- ◯ Venogram

Cancer Diagnosis:

Active Cancer Treatment: *Please list current anti-cancer drugs.*

☐ Confirm patient has received a 24-hour dose of dalteparin *(round up to the next syringe size)*
dalteparin 200 IU/kg x wt _____ kg = _____ IU SC at: _____ ◯AM ◯PM on _____
dd-mmm-yyyy

☐ Confirm that patient has been given subcutaneous injection teaching and instructions to continue once-daily dalteparin and a SmartSample© card for free pre-filled syringes of dalteparin from a community pharmacy. Do NOT start oral anticoagulation unless discussed with VGH Hematologist on-call.

☐ Confirm that VGH Thrombosis Clinic Outpatient Treatment Program Information Sheet has been given to patient.

Date referral faxed: _____ **Physician signature:** _____
dd-mmm-yyyy