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 Perioperative Referral Form

Please provide the following information and fax the complete form and relevant reports to **604-875-5071**. Appointment will only be given if procedure date is provided. Incomplete referral forms will delay triaging. Referral form must be received at least 10 working days before procedure.

Patient Information *(on BC Health Card)*

Last Name: _____ First Name: _____ PHN: _____

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

Referring Physician

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

Office Tel: _____ Office Fax: _____

Physician Performing Procedure

◯ Same as referring physician ◯ Interventional radiologist

◯ Other: Last Name: _____ First Name: _____

Surgery Information:

Procedure: _____

Hospital Site: ◯ VGH ◯ UBC ◯ Other: _____

Procedure Date: _____ (**mandatory**) Estimated Length of Stay: _____ Days
dd-mmm-yyyy

Anticoagulant:

◯ Apixaban (Eliquis®)
◯ Rivaroxaban (Xarelto®)
◯ Edoxaban (Lixiana®)
◯ Dabigatran (Pradaxa®)
◯ Warfarin
◯ Dalteparin (Fragmin®)
◯ Enoxaparin (Lovenox® *or generic brand*)
◯ Tinzaparin (Innohep®)
◯ Other: _____

Indication for anticoagulation: *Check all that apply.*

☐ Mechanical heart valve
☐ Non-valvular atrial fibrillation with history of stroke/transient ischemic attack or systemic embolism
☐ Non-valvular atrial fibrillation and ALL of: age ≥ 75 yrs, heart failure, diabetes, hypertension
☐ Valvular atrial fibrillation *(eg. mitral stenosis)*
☐ Venous thromboembolism within last 3 months
☐ Cancer associated venous thromboembolism
☐ Antiphospholipid antibody syndrome
☐ Other: _____

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