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 Elective Referral Form

Please provide the following information and fax the complete form and relevant reports to **604-875-5071**.
Incomplete referral forms will delay triaging and prolong wait times. Typical wait time is 3-6 months.

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: ____________________

Reason for Referral: *Please select the most appropriate reason.*

- ◯ Duration of anticoagulation
- ◯ Investigation for thrombophilia
- ◯ Primary or secondary thromboprophylaxis
- ◯ Venous thromboembolism in unusual site(s)
- ◯ Complicated anticoagulation management *(e.g., cancer, APS, recurrent VTE)*
- ◯ History of heparin-induced thrombocytopenia
- ◯ Other: ____________________________________

Requested Timeline:

- ◯ Within 1 month *(must call Thrombosis Clinic nurse at* ***604-675-2481*** *extension* ***4*** *to discuss)*
- ◯ Within 1 - 3 months *(must provide reason below)*
- ◯ 3 – 6 months *(typical wait time)*
- ◯ Next available appointment

Medical Information: *Brief summary OR attach consultation note.*

Medication List: *Current meds listed or a PharmaNet or EMR print out included in referral fax package. All current anticancer therapies must be provided.*

☐ **Laboratory Results:** *Relevant laboratory reports (e.g., CBC, creatinine, INR/PTT, thrombophilia testing) are included in referral fax package.*

☐ **Diagnostic Imaging:** *Relevant radiology reports of previous thrombosis (ultrasound, CT scan, VQ lung scan, venography, MRI) are included in referral fax package.*

Date referral faxed: ____________________ **Physician signature:** ______________________________
dd-mmm-yyyy