Date:	**Clot Assist VTE Outpatient Antithrombotic Therapy Requisition** **Pharmacare Pharmacy #5,** #139, 116 Carry Drive SE **Phone: 403.528.2111 Fax: 403.526.0655** **Dan Cell (403) 504 9778 if needed after hours**
Time:	

Patient Information and/or Label:

Name:______________________________________ DOB:_________________ Phone:______________________________

Address:____PHN:________________________________

Ordering Physician Name:____________________________ Specialty:___________________ Contact #:_______________

Most Responsible Physician Name: ____________________ Specialty:__________________ Contact #:_________________

To speak with the GPO or MO on call, call **<u>403 529 8817</u>** **and ask to speak to GPO/MO on call.**

Confirmation of DVT/PE:

☐ Lower extremity DVT	☐ PE
☐ Upper extremity DVT: (brachial, axillary, or more proximal vein involvement)	☐ Unusual site thrombosis: (brachial vein, splanchnic vein, cerebral vein, etc.)

Clotting and Bleeding Risk Information: Please proceed with therapy

☐ Type of Cancer:	☐ Angiogenesis inhibitors: (Bevacizumab, thalidomide, lenalidomide, sutent)
☐ Biological response modifiers (e.g. inteferon, rituximab, trastuzumab, tamoxifen)	☐ Nonspecific immunomodulating agents: (e.g. 5-florouracil, cisplatin, etc)
☐ L-asparaginase	☐ Recent major bleeding.
☐ Clotting disorder:	☐ Bleeding disorder:

Treat with LMWH in conjunction with current antiplatelet therapy:

☐ ASA	☐ Clopidogrel	☐ Prasugrel
☐ Ibuprofen/NSAID	☐ Ticagrelor	☐

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, **<u>as this patient is not currently receiving any therapy that would affect these values.</u>** 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. $25 injection fee for out of province patients.

Prescription duration: ☐ 30 days ☐ 3 months ☐ 6 months ☐ Other _________________________________

If desired, specify: LMWH ____________________________Special dosing instructions:__________________________

Fax to 403 526 0655 – Pharmacare Pharmacy #5, 139 - 116 Carry Drive Southeast, Medicine Hat, AB T1B 3Z8

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