Date:	**ClotAssist VTE Outpatient LWMH Requisition**
Time:	SRx Pharmacy, B01-8625 112 St NW, Edmonton **Phone: 587.454.2413 Fax: 587.454.0885**

Patient Information and/or Label:

Name:_______________________________________ DOB:_________________ **Cell Phone:___________________________**

Address:____PHN:_________________________________

Ordering Physician Name:_____________________________ **Specialty:____________________** **Contact #:________________**

Most Responsible Physician (MRP): ____________________ **Specialty: ___________________** **Contact #: _______________**

Pharmacy to fax summary to: ☐ Medical Oncology 780 432 8888 ☐ Other: ________________

Confirmation of DVT/PE:

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

IF APPLICABLE Treat with LMWH in conjunction with current antiplatelet therapy:

☐ ASA ☐ clopidrogrel ☐ prasugrel ☐ ibuprofen/NSAID ☐ ticagrelor

IF APPLICABLE Discontinue current oral anticoagulant therapy:

Drug Name: ☐ apixaban ☐ dabigatran ☐ edoxaban ☐ rivaroxaban ☐ warfarin ☐ other: ________________

☐ 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, **as this patient is not currently receiving any therapy that would affect these values.** The pharmacist will prescribe LMWH, give the patient lab work to measure CBC and CrCl immediately, and adjust dose accordingly 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.

Desired treatment duration: ☐ 30 days ☐ 3 months ☐ 6 months ☐ Lifetime ☐ other: _____________________

If desired, specify: LMWH ___________________________ Special dosing instructions: ____________________________

Fax to 587.454.0885 – SRx Pharmacy, B01 – 8625 112 St NW, Edmonton

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