Date:	**ClotAssist VTE Outpatient LWMH Requisition**
Time:	SRx Pharmacy, 4525 Monterey Ave NW, Calgary **Phone: 403.286.0013 Fax: 403.286.0018**

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 403-283-1651 ☐ BMT 403-521-3644 ☐ Hematology 403-521-3799
☐ Other: _____

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:

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 403 286 0018 – SRx Pharmacy, 4525 Monterey Ave NW, Calgary