

Date: _____	<b>ClotAssist VTE Outpatient LWMH Requisition</b>
Time: _____	SRx Pharmacy, 4525 Monterey Ave NW, Calgary <b>Phone: 403.286.0013 Fax: 403.286.0018</b>

**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:**

<input type="checkbox"/> Lower extremity DVT	<input type="checkbox"/> PE
<input type="checkbox"/> Upper extremity DVT: (brachial, axillary, or more proximal vein involvement)	<input type="checkbox"/> Unusual site thrombosis: (brachial vein, splanchnic vein, cerebral vein, etc.)

**Clotting and Bleeding Risk Information: Please proceed with therapy**

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

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

ASA  clopidogrel  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**

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