Alberta Health Services

Affix patient label within this box

# Anticoagulation Management Services Referral

**Fax completed referral form, ED chart, history, diagnostic procedure results to:**

**FMC** Phone: 403-944-2784 Fax: 403-944-8174 **RGH** Phone: 403-943-5584 Fax: 403-250-1894

**PLC** Phone: 403-943-5584 Fax: 403-250-1894 **SHC** Phone:403-956-2811 Fax: 403-956-2849

| | | | |
|---|---|---|---|
| Date *(yyyy-Mon-dd)* | | ☐ Inpatient ☐ Outpatient ☐ Community | |
| Location<br>Site _____ Unit _____ | | Referring practitioner | |
| **Indication for Anticoagulation** | | | |
| ☐ **Atrial Fibrillation** | ☐ Valvular<br>☐ Non-Valvular | CHADS2/CHA2DS2 VaSc Score | HASBLED Score |
| | ☐ Recent/current bleeding less than 14 days | Antiplatelet therapy | |
| ☐ **Venous Thromboembolism (VTE)** | ☐ DVT<br>☐ PE | ☐ High risk superficial vein thrombosis<br>☐ Massive clot/iliofemoral clot | |
| ☐ Active Cancer | ☐ Pregnancy | ☐ Thrombophilia _____ | |
| **Other Indication for Anticoagulation** | | | |
| ☐ Cardiomyopathy | ☐ Bioprosthetic valve less than 3 months | ☐ Pulmonary Hypertension | ☐ Other: |
| ☐ Ejection Fraction less than to 20% | | ☐ Mechanical valve: ☐ Mitral ☐ Aortic | |
| ☐ Acute MI/Ant STEMI | ☐ Thrombotic Stroke | ☐ LV clot | ☐ Arterial Thrombosis |

**Reason for Referral**

Check all that apply:

☐ Warfarin initiation

☐ LMWH initiation

☐ Peri-procedural anticoagulation management
in ☐ High risk clotting
and/or ☐ High risk bleeding

☐ Chronic anticoagulation with labile INR in high risk clotting or bleeding patient

☐ DOAC initiation in high risk clotting or bleeding patient

**Other Anticoagulation Considerations**

Renal Disease: ☐ Yes ☐ No Serum Creatinine _____ umol/L Date *(yyyy-Mon-dd)* _____

Duration of Anticoagulation: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Indefinite ☐ Unknown

Current Drug Coverage: ☐ Alberta Blue Cross ☐ Other insurance/drug plan ☐ No drug coverage

**Current Prescribed Therapy**

| | | | |
|---|---|---|---|
| ☐ ASA/Antiplatelet | ☐ Warfarin | Dose _____ | INR range _____ |
| ☐ LMWH _____ | | ☐ DOAC _____ | |

Additional anticoagulation assessment required:

☐ No ☐ Yes Indication _____ Urgency _____ Referral sent: ☐ Yes ☐ No *(if yes, please attach)*

☐ Cardiology ☐ Cardiac Sx ☐ General Internal Medicine ☐ Hematology ☐ Neuro ☐ Vascular Sx

| | | |
|---|---|---|
| Practitioner's signature | Date *(yyyy-Mon-dd)* | Pager or contact number |