Alberta Health Services

Thrombosis Central Access & Triage Referral

For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN
MRN	
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown	

Referral Source

☐ Emergency Room (ER)

☐ Family Physician _____

☐ In-patient Unit/Clinic _____ Date of discharge *(dd-Mon-yyyy)* _____

Referring Physician	**Family Physician** *(if different from referring physician)*
Name	Name
Phone	Phone
Fax	Fax

Reason for Referral

☐ Acute Venous Thromboembolism (VTE) Management

☐ Thrombosis Investigation

☐ Consult Only

Diagnosis

Date Diagnosed *(dd-Mon-yyyy)*

☐ Deep Vein Thrombosis (DVT) confirmed

☐ Pulmonary Embolism Confirmed

☐ Superficial thrombosis

☐ Other diagnosis _____

Relevant History

Anticoagulation prescribed	Duration prescribed

Allergies

Investigations Complete

☐ Ultrasound ☐ CT ☐ VQ ☐ Other _____

☐ CBC ☐ PT, PTT, INR ☐ creatinine ☐ D-dimer

Height *(cm)*	Weight *(kg)*