



**ST. PAUL'S HOSPITAL
THROMBOSIS CLINIC
REFERRAL**



Internal Medicine
Referral

Patient name: _____
PHN: _____ Male Female
DOB: _____ Other: _____
(dd/mmm/yyyy)

The Thrombosis Clinic provides comprehensive assessment and management for patients with venous or arterial thromboembolism. Physicians at the Thrombosis Clinic are members of Thrombosis Canada and International Society on Thrombosis and Haemostasis (ISTH).

DATE OF REFERRAL: _____

***All referrals will be triaged and prioritized**

Patient address: _____
City: _____ Province: _____
Postal code: _____ Email: _____
Home phone: _____
Cell phone: _____
Work phone: _____
Mobility aids: _____ Other concerns: _____
 Interpreter required Language: _____

URGENCY:

- Urgent (within 48 hours) – Page the on-call Thrombosis physician
 Non-urgent

REASON FOR REFERRAL: (check all that apply)

- Deep vein thrombosis – date of ultrasound _____
 Pulmonary embolism – date of CTPA or V/Q scan _____
 Venous thromboembolism in unusual site – date of relevant imaging _____
 Arterial thromboembolism – date of relevant imaging _____
 Perioperative anticoagulation management – date and type of surgery _____
 Investigation and/or counselling for thrombophilia – please specify _____
 Venous thromboembolism in pregnancy – please specify _____
 Other – please specify: _____

CURRENT ANTICOAGULANT THERAPY:

- warfarin low molecular weight heparin dabigatran rivaroxaban apixaban Other: _____

REFERRING PROVIDER:

Printed name: _____ MSP #: _____
Phone: _____ Fax: _____
Email: _____

FAMILY PHYSICIAN: Same as above

Printed name: _____ MSP #: _____
Phone: _____ Fax: _____

STAMP

*** For prompt booking, ensure all sections are fully completed.
Please include medication list, consult notes, and relevant investigations.**

FAX COMPLETED REFERRAL TO: 604-602-8652
Location: St. Paul's Hospital, Thrombosis Clinic
Rm 5900, 5th floor Burrard Building, 1081 Burrard Street, Vancouver, BC, V6Z 1Y6
Phone: 604-806-9455