

# REFERRAL

## Thromboembolism Clinic

4<sup>th</sup> floor, Cardinal Carter Wing, Squires Reception

T: 416-864-6060 x 3180

F: 416-864-6089

E: VTE@smh.ca

Patient's Name:		
Address:		
Contact Numbers:		
Health Card #		Date of Birth:
Assistance Needed? Y I N Coming via Wheel Trans? Y I N Mode of transport: Ambulatory Wheelchair Stretcher	Does patient require translator? Y I N Hearing impaired? Y I N	Language:
Diagnosis: DVT/PE Possible Hereditary Thrombophilia Cancer-Associated Thrombosis Thrombosis in Pregnancy Arterial Thrombosis Other (please specify) _____		
Reason for Referral: Consultation only / Second opinion Annual Expert Review & Recommendations Shared Care Assume Ongoing Care (please note ne do not provide ongoing anticoagulant/ INR monitoring)		Medication: Warfarin Stop date if applicable _____ Rivaroxaban Stop date if applicable _____ Apixaban Stop date if applicable _____ Dabigatran Stop date if applicable _____ LMWH Stop date if applicable _____ None of the above
Clinical details for referral: Please provide relevant clinical information and a brief description of thromboembolism or anticoagulation issues to be address in clinic.		
Are there any pending investigations?		
PLEASE ATTACH results of relevant investigations that are not available on the St. Michael's Hospital system, specifically: Ultrasound/Doppler, CTPE, VIQ		
Referring MD	Name Address Tel # Fax #	