

REFERRAL to
Thromboembolism Clinic
 4th floor, Cardinal Carter Wing, Squires Reception
 T: 416-864-6060 x 3180 F: 416-864-5714 E: vte@smh.ca

Patient's Name:	
Address:	
Contact Numbers:	
Health Card #:	Date of Birth:
Assistance Needed? Y/N Coming via WheelTrans? Y/N Mode of transport: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher	Does patient require translator? Y / N Language: Hearing impaired? Y/N
Diagnosis: <input type="checkbox"/> DVT/PE <input type="checkbox"/> Possible Hereditary Thrombophilia <input type="checkbox"/> Cancer-Associated Thrombosis <input type="checkbox"/> Thrombosis in Pregnancy <input type="checkbox"/> Arterial Thrombosis <input type="checkbox"/> Other (please specify) _____	
<input type="checkbox"/> URGENT	
Reason for Referral: <input type="checkbox"/> Consultation only / Second opinion <input type="checkbox"/> Annual Expert Review & Recommendations <input type="checkbox"/> Shared Care <input type="checkbox"/> Assume Ongoing Care <i>(please note we do <u>not</u> provide ongoing anticoagulant/ INR monitoring)</i>	Medication: <input type="checkbox"/> Warfarin <i>Stop date if applicable</i> _____ <input type="checkbox"/> Rivaroxaban <i>Stop date if applicable</i> _____ <input type="checkbox"/> Apixaban <i>Stop date if applicable</i> _____ <input type="checkbox"/> Dabigatran <i>Stop date if applicable</i> _____ <input type="checkbox"/> LMWH <i>Stop date if applicable</i> _____ <input type="checkbox"/> 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, V/Q	
Referring MD	Name Address Tel# Fax # Ref #