BC Cancer Agency
CARE & RESEARCH

Referral To Thrombosis Clinic Out Patient Program (VGH)

REMINDER: Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form

DATE:

Acute Venous Thromboembolism Inclusion/Exclusion Criteria

Date of VTE Diagnosis: _____ (dd/mm/yy)

INCLUSION CRITERIA

Please indicate type/site of venous thrombosis (check all that applies):

- ☐ Proximal leg DVT (common femoral, superficial femoral popliteal vein)
- ☐ Distal leg DVT (posterior tibial, anterior tibial, peroneal vein)
- ☐ Catheter-related DVT (subclavian, axillary, cephalic, jugular vein)
- ☐ Arm/Neck DVT (subclavian, axillary, cephalic, jugular vein)
- ☐ Stable PE (no acute syncopal episode, vital signs must be stable with walking, O_2 sat greater than 92% on room air on exertion, no prior cardiopulmonary disease, pain easily controlled)
- ☐ Other. Please specify: _____ and call the Thrombosis Clinic (tel: 88-69275).

EXCLUSION CRITERIA

All Must Be No For Enrollment

Yes	No	Criteria:
		Clinically unstable for outpatient therapy
		Active bleeding, familial (e.g., hemophilia) or acquired (e.g. DIC) bleeding disorder
		Severe uncontrolled hypertension (systolic BP greater than or equal to 180 mmHg or diastolic BP greater than or equal to 110 mmHg)
		Platelet count less than 50 X 10^9/L
		History of heparin-induced thrombocytopenia (HIT) or other allergies to anticoagulants
		Renal failure requiring dialysis
		Liver failure with coagulopathy
		Require hospitalization for other reasons (e.g., phlegmasia cerulea dolans, pain control)

COMMENTS FROM ONCOLOGIST

DOCTOR'S SIGNATURE:

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Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BCCA treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

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DATE:

Referring MD: _____ Date of Referral: _____ Time: _____

Cancer Diagnosis: _____Chemotherapy protocol: _____

Date of last chemotherapy given: _____ No. of last cycle received: _____

Most recent blood work: Date: _____

WBC: _____x 10^9/L Hb: ____g/L Plt: _____x 10^9/L Creat:_____ mol/L CrCl:____ mL/min

Medication:
Pharmacy consult to provide SmartSample® card: 1 card/patient signed by physician to obtain 5 free prefilled dalteparin syringes from Community Pharmacy.

Dose of pre-filled syringe prescribed: _____ IU.

If tomorrow is a weekend or statutory holiday, Pharmacist to provide anticoagulation patient counseling.

Dalteparin (Fragmin®) 200 units/kg x Wt (_____ kg) = _____ IU SC at BCCA (round dose up to nearest 500 IU) (Maximum daily dose 25,000 IU).

First dose to be administered at BCCA.

If tomorrow is a weekend or a statutory holiday, Nurse consult for provision of subcutaneous injection teaching.

Provide patient with the Thrombosis Clinic Outpatient Treatment Information Sheet.

Referral to Thrombosis Clinic:
Unit Clerk to fax these pre-printed orders to the Thrombosis Clinic (**fax 604-875-5071**).

Unit Clerk to contact Release of Information Office (L2336) to arrange to fax last BCCA clinic note and radiology report confirming DVT/PE to Thrombosis Clinic (**fax 604-875-5071**).

Appointment Booking:
If tomorrow is a weekday, the Thrombosis Clinic will call patient before 9 am with an appointment time.

Patient home phone: _____ Patient cell phone: _____

If tomorrow is a weekend or statutory holiday, call the Thrombosis Clinic (tel 88-69275) to arrange for patents appointment on the next work day.

Nursing and Unit Clerk Notes

Date/Time given:

DOCTOR'S SIGNATURE:

RN SIGNATURE: