Thrombosis Program
Vancouver Coastal Health, University of British Columbia

VGH Thrombosis Clinic
Blackmore Pavilion, 6th Floor
855 West 12th Avenue
Vancouver, BC V5Z 1M9

Tel: 604.675.2481
Fax: 604.875.5071

Perioperative Referral for Patients on Oral Anticoagulant

A. Surgery date MUST be provided before an appointment is given.
B. Please include patient's CBC and creatinine.
C. Complete all fields, sign and fax to (604) 875-5071.

Patient Information

Last Name: _____ First Name: _____

PHN: _____ DOB: _____ DD/MM/YYYY

Contact Tel: _____ Alternate Tel: _____

Anticoagulant:
- ◯ dabigatran (Pradaxa®)
- ◯ rivaroxaban (Xarelto®)
- ◯ apixaban (Eliquis®)
- ◯ edoxaban (Lixiana®)
- ◯ warfarin

Surgery Information

Name of Surgeon: _____ Tel: _____ Fax: _____

Procedure: _____

Hospital Site: ◯ VGH ◯ UBC ◯ SPH ◯ Other: _____

Procedure Date: _____ (**mandatory**) Estimated Length of Stay: _____ Days
DD/MM/YYYY

Patient Risk Factors *(check all that apply)*

- ☐ Mechanical heart valve
- ☐ Atrial fibrillation with history of stroke/TIA or systemic embolism
- ☐ Atrial fibrillation and **ALL** of: age ≥ 75 yrs, CHF, diabetes, HTN
- ☐ Atrial fibrillation and rheumatic heart disease *(eg. mitral stenosis)*
- ☐ DVT or PE within last 3 months
- ☐ Cancer associated with VTE
- ☐ Antiphospholipid antibody syndrome
- ☐ Other: _____

Signature _____ Name _____ Date _____ DD/MM/YYYY