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Thromboembolism Service Referral Form

Thromboembolism Service, St. Catharines Site
Monday to Friday 0800 – 1600 (For Urgent after hours referrals, contact 905–685–8082)
905–378–4647 Ext. 45711 Fax: 905–704–4408

Patient's Name:	Date of Referral (dd/mm/yyyy):
Address:	
Contact Numbers:	
Health Card Number:	Date of Birth (dd/mm/yyyy):
Referring Physician:	Contact Number:
Allergies:	Weight:

Reason for Referral:

- ☐ Acute VTE Management
- ☐ VTE Prophylaxis / Extended Prophylaxis
- ☐ Anticoagulant Management
- ☐ Peri–Procedural Anticoagulation Management
- ☐ Other:

Please Specify:

- ☐ Inpatient Referral
- ☐ Outpatient Referral

Anticipated Discharge Date (dd/mm/yyyy): _____

Planned Procedure / Surgery and Date (dd/mm/yyyy):

Diagnosis:

History:

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29/Jun/2020 14:39

Physician Signature

Date (dd/mm/yyyy)

Fax Form To: 905–704–4408

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