Anti-Coagulation Clinic Referral Form

First Available General Internal Medicine

Phone 250 940 4444 Fax 250 385 9600

Date:

PATIENT INFORMATION: (affix label or complete)	**REFERRING PHYSICIAN:** (affix label or complete)
Name:	Name:
PHN:	MSP:
DOB:	Address:
Address:	Phone:
Cell Phone:	Fax:
Home Phone:	
Email:	**FAMILY PHYSICIAN:**
Secondary Contact:	

Urgency: ❒ < 1 week ❒ < 2 weeks ❒ < 1 month ❒ Non-Urgent

REFERRAL FOR (check all that apply):

❒ Peri-Procedural Anti-Coagulation / Anti-Platelet Management
❒ DVT/PE Prophylaxis Assessment in High Risk Peri-Operative Patient
❒ Anti-Coagulation Advice and/or Initiation

❒ ****Full Pre-Operative General Internal Medicine Consult is Also Required****

Type of Procedure:

Type of Anesthesia: ❒ None ❒ Local ❒ Neuro-Axial/Spinal ❒ General

Surgical Date (if known):

Bleeding Risk From Procedure: ❒ Low ❒ Medium ❒ High

Anticipated Day(s) Post-Procedure in Which Anti-Coagulation or Anti-Platelet Can Be Restarted
(Assuming Full Clinical Benefit On Start Day): ❒ 1 ❒ 2 ❒ 3 ❒ 4 ❒ Other _____

Drug(s) Patient is On Which Require(s) Peri-Procedure Management:

❒ Anti-Coagulation Therapy ❒ Anti-Platelet Agent

Indication For Anti-Coagulation or Anti-Platelet Therapy:
❒ Atrial Fibrillation
❒ Deep Vein Thrombosis/Pulmonary Embolism
❒ Mechanical Heart Valve
❒ Hypercoagulable Disorder
❒ Coronary Artery Disease
❒ Cerebral or Peripheral Vascular Disease
❒ Other _____

Patients will be contacted by Rebalance[MD] directly to schedule appointment

Referring physicians will be advised by fax once this referral has been received, and, again, when an appointment has been offered to the patient

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