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Thrombosis Clinic Referral
Jim Pattison Outpatient Care and Surgery Centre

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Jim Pattison Outpatient Care and Surgery Centre – MD Thrombosis Clinic
9750 140 Street, Surrey BC, V3T 0G9
Tel: 604-582-4550 ext. 763869 (IM Thrombosis) and 764191 (Hematology Thrombosis) Fax: 604-528-5435

Instructions

- This is a referral to the Thrombosis Clinic MD for confirmed venous thromboembolic disease.
- Fax completed form and include relevant imaging and most recent blood work (CBC, renal and liver function) to 604-528-5435. Incomplete referrals will be rejected.
- If a referral to the pharmacist anticoagulation management (ACM) clinic for pharmacy-led warfarin and/or LMWH administration is desired, complete the ACM Clinic Pharmacist Referral (MSXX104191).
- Our clinic does not accept referrals for patients with peripheral vascular disease or for anticoagulation management of cardiac conditions.
- For urgent hematology advice required within 24 to 48 hours, contact the on-call SMH Hematologist.

Patient Information

Patient's legal full name: _____
Last First Middle Initial
Preferred name: _____ Sex assigned at birth: ☐ Female ☐ Male ☐ Intersex
Gender: ☐ Woman ☐ Man ☐ Other (please specify): _____
Pronouns: ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other (please specify): _____
Personal health number: _____ Date of Birth (DD/MM/YYYY): _____
Home phone: _____ ☐ Okay to leave message
Mobile phone: _____ ☐ Okay to leave message
Address: _____
Street City Province Postal Code
Email: _____
Alternate contact name: _____ Alternate contact phone number: _____
Insurance (if non-MSP): _____ Interpreter required: ☐ Yes language: _____
Isolation precautions: ☐ Airborne ☐ Contact ☐ Droplet ☐ N/A
Referral priority: ☐ Routine ☐ Urgent (provide rationale below):
Reason for urgency:

Referral Information

Services requested:

☐ Assessment of patients with venous thromboembolism (VTE) *(note:* initiation of anticoagulation, if indicated, should be done prior to referral)

Reason for referral:

Medical history (if consultations not attached):	**Current medications** (if medication list not attached):

Referring Provider
Name: _____ Signature: _____ MSP: _____
Phone: _____ Fax: _____ Date (DD/MM/YYYY): _____
Specialty: _____ Primary care provider (if different): _____

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