

Thrombosis and Hemostasis Program Patient Referral Form

There are 4 Easy Steps for referring a patient to our program. Please type or write to fill in the form.

1. Patient / Provider Identifying Information

Date: _____ Diagnosis: _____

Patient Last Name: _____ First name: _____

Patient Address: _____

Patient phone (with area code): _____

Referring Provider: _____ Office Contact person: _____

Office phone: _____ Town, State: _____

2. Reason for Referral mark the reason and include requested records; check all that apply

H/O deep vein thrombosis or pulmonary embolus (DVT or PE)

_____ Office notes, problem list, medication list

_____ Discharge Summary

_____ Imaging report (ultrasound/CT/VQ Scan)

_____ Relevant Labs

Thrombophilic condition without Thrombosis History. **List Type here:** _____

_____ Lab reports documenting this

_____ Office note, problem list, medication list

Pregnancy Complications, specify here _____

_____ Office notes, problem list, medication list

Post-thrombotic Syndrome

_____ Information as per DVT/PE above.

Abnormal Bleeding History or known bleeding disorder

_____ Office notes, problem list, medication list

_____ Previous diagnostic lab tests if done

Need for Surgery. **List type here:** _____

Problems managing anticoagulation. **List nature of problem:** _____

_____ **For patients on warfarin, please include the Anticoagulation Flow Sheet**

3. State a specific question you would like addressed here. If you have a preferred time frame for the appointment, list it here: _____

**4. Fax this form to us at: Thrombosis and Hemostasis Program, FAHC Hematology-Oncology
802-847-1258**

Appt Date:

Notes requested Date:

Pt Notified Date:

NPV Paperwork sent Date: