

## **Thrombosis and Hemostasis Program Patient Referral Form**

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

### **1. Patient / Provider Identifying Information**

Date: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient phone (with area code): \_\_\_\_\_ FAHC mrn: \_\_\_\_\_

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**

**FOR OFFICE USE:**

**Appt Date:**

**Notes requested Date:**

**Pt Notified Date:**

**NPV Paperwork sent Date:**