Thrombosis Program
Vancouver Coastal Health, University of British Columbia

VGH Thrombosis Clinic
Blackmore Pavilion, 6th Floor
855 West 12th Avenue
Vancouver, BC V5Z 1M9

Tel: 604.675.2481
Fax: 604.875.5071

Thrombosis Assessment Elective Referral

A. This referral has a 3-6 month waiting period.

B. To facilitate triaging of this referral, please include:
- List of medications
- Recent CBC and creatinine or other related bloodwork results
- Diagnostic reports, for example ultrasound, CT scan, VQ lung scan, venography, MRI

C. Complete all fields, sign and fax to (604) 875-5071.

Patient Information

Last Name: ______________ First Name: ______________ PHN: ______________

Address: ______________ | ______ | ______________ | BC | ______________
No. and Street | Apt./unit | City/Town | Province/Territory | Postal Code

Contact Tel: ______________ Alternate Tel: ______________

Referring Physician

Last Name: ______________ First Name: ______________ Billing Number: ______________

Office Tel: ______________ Fax Number: ______________

Reason for Referral:

Medical Information *(Current dictated clinic note or history)*

______________ ______________ ______________
Signature Name Date DD/MM/YYYY