Capital Health

Thrombosis - Anticoagulation Program

Peri-operative Referral Form

Telephone: 473-7985 Fax: 473-6260

Date: _____

Name: _____ DOB: _____

HUN/HCN: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

*****Please note that a date for the procedure must be given*****

Please answer the following:

- **Reason for Warfarin:** _____
- **Current Warfarin Dose:** _____
- **Surgery/Procedure Date:** _____
- **Surgical/Procedure Type:** _____
- **Physician Performing Surgery/Procedure:** _____
- **Physician's fax number** _____
- **Anaesthesia, if applicable (general/regional):** _____

Comments: (Bleeding risk?)

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