



**CARDIAC SCIENCES ANTICOAGULATION
PRE-ANGIOGRAM THROMBOTIC RISK FORM**

Patient Name (Please Print): _____

Date of Birth (day/month/year): _____

Personal Health Information Number (PHIN) _____

You have indicated that your patient is on Warfarin. Please complete the following form for assessment of thrombotic risk and to determine the need for LMWH. **Your patient cannot be scheduled for their procedure until this form is completed and faxed back to 235-3586.** If bridging is indicated, the Cardiac Sciences Program Anticoagulation Clinic will initiate bridging in the periprocedural period.

Please check the appropriate indication:

Valvular heart disease No Yes

Atrial fibrillation No Yes

With one or more risk factors (check those that apply):

Heart failure Diabetes Mellitus Hypertension Prior CVA/TIA Age > 75

History of CVA/TIA No Yes Date of CVA/TIA: _____

Mechanical heart valve No Yes Date of implant: _____ aortic mitral

DVT / PE No Yes Date: _____

Other Indication (please list): _____

Does your patient have a history of Heparin Induced Thrombocytopenia? No Yes

Patient Thrombotic Risk (please check): Low Intermediate High

Does this patient require bridging with LMWH? No Yes

Form completed by (Physician signature): _____

**St. Boniface Hospital
Cardiac Sciences Anticoagulation Clinic
Ph: 258-1258 Fax: 258-1347**

Legend:	DVT - Deep Vein Thrombosis	PE - Pulmonary Embolus
LMWH - Low Molecular Weight Heparin	CVA - Cerebrovascular Accident	TIA - Transient Ischemic Attack

For Anticoagulation office use only:

Patient Risk: Low Intermediate High Bridging: No Yes