Haematology Service Referral Form

Date: _____

☑ Thrombosis Clinic 6 Week Follow-up

☐ INR Monitoring (please tick if required)

Please email to Haematology with a copy of the ultrasound report to:
blood@midcentraldhb.govt.nz

Name _____

PATIENT ID LABEL

Address _____

Cell _____ **Home** _____

NHI _____ **DOB** _____ **Gender** _____

GP/NP Name _____

Practice Name _____ **Phone** _____

Provider to nominate one of the following care pathways *(please tick)*:

- ☐ **Warfarin – GPT and Haematology titration**
  (Haematology to do initial INR monitoring – the patient's care will be transferred back to GP Team to organise MedLab dosing)
- ☐ **Warfarin – GPT titration**
- ☐ **Dabigatran**
- ☐ **Rivaroxaban**

Location of DVT:

Provoking factors:

If patient is on warfarin please complete the following:

- Dose of Warfarin: _____
- Day 4 INR due date: _____