



University Specialty Pharmacy  
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## Deep Vein Thrombosis

Patient Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Patient's Height: \_\_\_\_\_ Patient's Weight: \_\_\_\_\_ Male  Female

Parent/Guardian if child: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ **PLEASE ATTACH COPY OF CARD!**

Cardholder Name: \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Employer: \_\_\_\_\_

Patient Drug Allergies: \_\_\_\_\_

**CLINICAL INFORMATION**

Expected Date of First/Next injection: \_\_\_\_\_ Date of last Injection: \_\_\_\_\_

Nursing Needed: \_\_\_\_\_ Nursing Agency: \_\_\_\_\_

**PRESCRIPTION**

Arixtra  
 Fragmin  
 Lovenox  
 Innohep

SIG: Inject Dose: \_\_\_\_\_ mg/units  SQ Frequency: \_\_\_\_\_

Prophylaxis: \_\_\_\_\_ Dispense Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

Other Instructions: \_\_\_\_\_

Deliver Product to:  Office  Patient's Home  Hospital: \_\_\_\_\_ Room#: \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** \_\_\_\_\_  
**Date**

Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

DEA #: \_\_\_\_\_ License #: \_\_\_\_\_ NPI#: \_\_\_\_\_ State: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Email: \_\_\_\_\_

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