MANAGEMENT OF APIXABAN (ELIQUIS®) BEFORE AND AFTER MEDICAL PROCEDURES OR SURGERY

This form should be completed by your doctor. It provides instructions on when to take your apixaban (Eliquis®) if you are having a procedure or surgery.

Date of procedure: _____

Procedure: _____

Indication(s) for anticoagulation: _____

MRN:

Name:

DOB:

Usual APIXABAN dose: _____ Calculated CrCl (mL/min) (kidney function): _____

Bleeding risk:

☐ MINIMAL ☐ LOW ☐ HIGH

Consulted with specialist performing the procedure: ☐ YES ☐ NO

Comments:_____

Thrombotic (clotting) risk:

☐ LOW ☐ MODERATE ☐ HIGH

Consulted with specialist managing anticoagulation: ☐ YES ☐ NO

Comments:_____

Show this form to the doctor at any appointments **BEFORE** your procedure. Bring this form to your procedure.

When to take APIXABAN BEFORE your procedure

Continue to take your APIXABAN as usual until ____/____/____

Number of days before surgery	4	3	2	1	Day of procedure
Date					
MORNING dose				None	None
EVENING dose				None	None

If you require further information please contact: _____on_____

Doctor name: _____ Signature: _____

Designation: _____ Phone Contact: _____ Date: _____

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Taking APIXABAN AFTER your procedure

Date of procedure: _____

Procedure: _____

MRN:

Name:

DOB:

Complete this form with your surgeon or proceduralist **AFTER** your procedure.

When to take APIXABAN AFTER your procedure:

Number of days after procedure	Day of procedure	1	2	3	4	5	6
Date							
MORNING Dose	None						
EVENING Dose	None						

Then, continue to take your APIXABAN as normal from ____/____/____

Show this form to your doctor during any appointments straight AFTER your procedure.

If you require further information please contact: _____on_____

Instructions if you notice any signs of bleeding AFTER your procedure

Signs of bleeding may include:_____

Please contact_____on_____ if you notice any of these signs.

If the bleeding is severe, go straight to your nearest Hospital Emergency Department.
Tell them you are taking APIXABAN

Doctor name: _____ Signature: _____

Designation: _____ Phone Contact: _____ Date: _____

For information on managing APIXABAN refer to the CEC NOAC Guidelines Updated July 2017 http://bit.ly/2q4ObP5

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