PRISMA HEALTH

Anticoagulation Clinic Referral Form

**Phone: (864) 522-3340
Please fax referral form to (864) 522-3345

Patient Name_____ **Medical Record #**_____ **Date of Birth** ___/___/____

Telephone Number (_____)_____-_____ **Alternate Telephone Number** (_____)_____-_____

Diagnosis (please be specific)

- ☐ DVT
- ☐ Recurrent DVT
- ☐ PE
- ☐ Recurrent PE
- ☐ VTE Prophylaxis
- ☐ Atrial Fibrillation
- ☐ Aortic Mechanical Heart Valve
- ☐ Mitral Mechanical Heart Valve
- ☐ Heart Failure
- ☐ Other _____
- ☐ CVA/TIA
- ☐ CAD
- ☐ *Hypercoagulable State

***please specify if known**_____

Target INR Range

☐ 2.0–3.0 ☐ 2.5–3.5 ☐ *Other _____

***please specify reasoning**_____

Recent Warfarin Dosing/INR History:

Most recent INR: _____ Date: _____
Current warfarin dose: _____
Warfarin tablet strength used:_____ mg
Currently on LMWH: ☐ yes ☐ no Lovenox Dose:_____

Duration of Therapy

☐ 3 months ☐ 6 months ☐ 12 months ☐ Lifelong ☐ Other _____

Pertinent Past Medical/Social History

- ☐ HTN
- ☐ Anemia
- ☐ Malignancy
- ☐ Diabetes
- ☐ Heart Failure
- ☐ Alcohol Abuse
- ☐ CAD
- ☐ Previous CVA
- ☐ History of GI Bleed
- ☐ Renal Insufficiency
- ☐ Hepatic Insufficiency
- ☐ Other_____

<u>Please choose one of the following and sign:</u>

☐ I am the **primary care provider or a specialist (i.e. cardiologist, vascular physician, pulmonologist, etc) who will be providing longitudinal care** to the patient indicated above and authorize the Anticoagulation Clinic to perform warfarin therapy monitoring and dose adjustments for this patient per their established policies/procedures.

_____ _____ _____ _____
Referring Physician (printed name) Signature Date Pager

☐ I am a **hospitalist or ER physician and have contacted the primary care provider** of the patient indicated above, who agrees to authorize the Anticoagulation Clinic to perform warfarin therapy monitoring and dose adjustments for this patient. **Please note, the <u>referring physician will be the responsible party should any issues arise for this patient in the Anticoagulation Clinic</u>, unless the patient's primary care provider or another physician agrees to authorize the Anticoagulation Clinic to perform warfarin therapy monitoring and adjustment per their established policies/procedures.

_____ _____ _____ _____
Referring Physician (printed name) Signature Date Pager

_____ _____ _____
Primary Care Physician Name Phone Number Fax Number