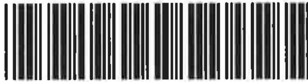
LIFEBRIDGE HEALTH.
CARE BRAVELY

Anticoagulation Clinic Referral Form

200 Memorial Ave.
Westminster, MD 21157
Phone: 410-871-6157 | Fax: 410-871-7199

Place Patient Label Here



94001

Patient Information

Name:____________________________ Birthdate:________ SS#:______________

Address:____________________ City:__________ State:_______ Zipcode:__________

Primary Care Physician:____________________ Phone Number:__________________

Insurance Information

Primary Plan Name:____

Primary Policy #: ____________________ Primary Group #:____________________

Primary Phone Number:____________________ Primary Pre Cert #:____________________

Primary Policy Holder Place of Employment:______________________________

Secondary Plan Name:____

Secondary Policy #:____________________ Secondary Group #:____________________

Secondary Phone #:____________________ Secondary Pre Cert #:____________________

Secondary Policy Holder Place of Employment:______________________________

ICD-10 for anticoagulation: ____

Diagnosis/Pertinent History/Reason for anticoagulation therapy:

____

____

____

Medication ☐ Warfarin ☐ Apixaban ☐ Rivaroxaban ☐ Dabigatran ☐ Edoxaban

1. Anticipated Duration: ☐ Life ☐ 3 Months ☐ 6 Months ☐ Other: ____________

2. Warfarin Only: ☐ INR=2.0-3.0 ☐ INR=2.5-3.5 ☐ Other: ____________

May patient take low dose aspirin (*ie. 81-165 mg*) if indicated? ☐ Yes ☐ No

Reporting Mechanisms:
Do you want clinic notes sent to you? ☐ Yes ☐ No

☐ Courier (Specify Office________________) ☐ Via mail (Specify Office________________)

I give my authorization for Carroll Hospital Anticoagulation Clinic to monitor and adjust anticoagulant dose of this patient based on established protocols, policies, and procedures.

____________________	____________________	________________
Physician Signature	Printed Name / Phone Number	Date & Time