



94001

Patient Information

Name: _____ Birthdate: _____ Patient Phone #: _____
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