

ANTICOAGULATION CLINIC REFERRAL

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Phone: 410-601-7303 Fax: 410-601-7304



Indication for Anticoagulation:

Northwest Hospital
Phone: 410-521-8875 Fax: 410-701-4558

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Patient:		
DOB:		
Date:		
Patient Phone #:		

Please attach patient's most recent H&P with updated problem list, medication list and pertinent labs (CBC, Chem7 and most recent INR), if available.

	Atrial Fibrillation/Flutter
	Pulmonary Embolus
	Venous Thrombosis
	Mechanical Heart Valve: Aortic/Mitral (please circle)
	Cardiomyopathy
	Cerebrovascular Accident (CVA)/Transient Ischemic Attack (TIA)
	Antiphospholipid Antibody Syndrome
	Other (Specify):
INR Thera	apeutic Range:
☐ 2 −3	☐ 2.5-3.5 ☐ Other (Specify):
Anticipate	d Duration:
☐ 3 mon	nths
<u>History</u>	
☐ Hx of	bleeding
Current A	nticoagulation & Dose (including Bridge Therapy):
This refer	rral gives LifeBridge Health Anticoagulation Services the authority to monitor and adjust the dosage of the ticoagulant in this patient. Please note patients will be contacted by the Anticoagulation clinic to be scheduled.
above and Until app	pointments are arranged, you will be responsible for continued monitoring of the patient.
	Physician Signature: Print name:
Phone: _	Fax:
☐ Chec	k here if this is the physician to contact regarding anticoagulation – related issues/questions. If not, the next nust be filled out completely:
Primary	Care (or contact) Physician Name:
Phone: _	Fax:

Per CMS requirement, all referrals to the Anti-Coagulation Clinic must be initiated by a physician.