

Anticoagulation Practice Referral Form

Patient Label Here

- Harper University Hospital 8 Brush Center
- UHC Rosa Parks Geriatric Center 5B
- Sinai-Grace Hospital Primary Care Clinic
- Huron Valley-Sinai Hospital
- 3990 John R, Detroit, MI 48201
- 4201 St. Antoine Blvd., Detroit, MI 48201
- 6001 West Outer Drive, Suite 114, Detroit, MI 48235
- 1 William Carls Drive, Commerce, MI 48382
- Phone: (313) 745-4679 Fax: (313) 745-9335
- Phone: (313)745-1741 Fax: (313)745-8165
- Phone: (313) 966-9234 Fax: (313) 966-9418
- Phone: (248) 937-3467 Fax: (248) 937-5083
- *Medicare or ≥60 years of age
- *Must be first seen in Internal Med Resident Clinic

Please PRINT and fill in ENTIRE FORM (ALL SECTIONS) and ensure that it is signed by an ATTENDING PHYSICIAN (For Sinai-Grace, must be signed by SGH RESIDENT PHYSICIAN). Please CALL to verify receipt of fax. IF ENROLLED, THE PATIENT WILL BE SEEN WITHIN 3-5 DAYS, OR AS DEEMED APPROPRIATE BY ANTICOAGULATION CLINIC. *PATIENTS MUST MEET CRITERIA TO BE ENROLLED IN THE ABOVE ANTICOAGULATION CLINICS.

Referral Date: _____
Referring Physician/Beeper: _____
Primary Care or Outpatient Physician: _____
Address: _____
PCP or Outpatient Physician phone and fax #: _____
PCP or Outpatient Physician pager #: _____
Patient Name: _____
Patient Address: _____
Phone: Home Phone: _____
Patient Cell Phone: _____
Patient DOB: _____
Patient MRN: _____

****DESCRIPTION OF DESIRED ANTICOAGULATION (PLEASE CIRCLE BELOW)****

Indication	Recommended INR and Duration	
Treatment of DVT (First Event/Reversible Cause)	2 - 3	3 Months
Treatment of DVT (First Event/Idiopathic)	2 - 3	3 Months then reevaluate by physician
Treatment of PE (First Event/Reversible Cause)	2 - 3	3 Months
Treatment of PE (First Event/Idiopathic)	2 - 3	3 Months then reevaluate by physician
Recurrent DVT/PE	2 - 3	12 months - indefinite
Treatment of DVT/PE (First Event with Cancer or hypercoagulable state)	2 - 3	12 months - indefinite
Atrial Fibrillation / Atrial Flutter (AF)	2 - 3	Indefinite
Aortic Valve Replacement (Mechanical) w/ no Risk Factors	2 - 3	Indefinite
Aortic Valve Replacement (Mechanical) w/ Risk Factors for thromboembolism: AF, left atrial enlargement, hypercoagulable state, low left ventricular ejection fraction, and prior thromboembolism	2.5 - 3.5	Indefinite
Mitral Valve Replacement (Mechanical)	2.5 - 3.5	Indefinite
Mitral Valve Replacement (Bioprosthetic) w/ no Risk Factors	2 - 3	3 Months
Bioprosthetic Replacement (Aortic or Mitral) w/ Risk Factors for thromboembolism: AF, left atrial enlargement, hypercoagulable state, low left ventricular ejection fraction, and prior thromboembolism	2 - 3	Indefinite

If other indication, or different prescribed INR/duration than above please fill in and provide rationale:

Past Medical History: _____

Drug Allergies (reaction): _____

Current Medications (Name, Dose & Frequency; attach separate sheet if needed): _____

Is this a bridge therapy patient? (circle one): **YES** **NO**

LMWH/fondaparinux and Dose: _____

Date:	Recent warfarin dosing: _____ mg daily					OR:	mg daily
Sun	Mon	Tue	Wed	Thur	Fri	Sat	
_____mg	_____mg	_____mg	_____mg	_____mg	_____mg	_____mg	_____mg

Recent Labs:

Date	Hgb/Hct	Platelets	BUN/Cr	INR

Physician Signature and Beeper: _____ **Date:** _____

By my signature, I understand that my patient will be dosed on warfarin and/or parenteral anticoagulant (LMWH/fondaparinux) by the clinical pharmacist of the Anticoagulation Practice according to established policies and procedures. In addition, I grant prescriptive authority for these agents. The clinical pharmacist may schedule appropriate laboratory draws and clinic visits according to the patient's need within the guidelines of the clinic policies and procedures. The referring physician is still responsible for the patient. The clinical pharmacists are working under the supervision of the referring physician, and/or primary care physician and/or the Medical Director for the respective Anticoagulation Clinic.