GBMC
6701 North Charles Street
Baltimore, MD 21204

Place patient label here

ANTICOAGULATION CLINIC REFERRAL FORM – Page 1 of 2
TEL: 443-849-2769 FAX: 443-849-6889

Referral Process:

- **Physician:** Please fax completed referral form and a copy of recent medical history to 443-849-6889.
- **AC clinic personnel** will contact patient to schedule appointment upon receipt of referral form.
- **UNTIL THE PATIENT CAN BE SEEN, WE REQUEST THAT ANTICOAGULATION THERAPY BE MONITORED UNDER YOUR CARE, OR THE SUPERVISION OF THE PATIENT'S PERSONAL PHYSICIAN.**
- **RESPONSIBILITIES OF THE AC CLINIC AFTER ACCEPTING PATIENT:**
  - Monitor the INR and adjust the dose of anticoagulant as appropriate
  - Fax progress notes to the referring/managing physician after every visit
  - Provide anticoagulant prescriptions to the patient
  - Report all appointment absences to the referring provider/PCP
  - Explain dismissal policy to the patient
  - Inform referring physician of critical INR levels greater than 6 and/or clinical bleeding and refer patient to the emergency department. For patients declining to go to emergency department, notice will be made to the referring physician/PCP the same hour
  - Provide report to referring physician at the end of treatment duration
- **RESPONSIBILITIES OF THE REFERRING PROVIDER:**
  - Complete referral form in its entirety (Pages 1 and 2)
  - Notify AC clinic if anticoagulant therapy has been stopped
  - Notify AC clinic of all elective procedures
  - Notify AC clinic of initiation or discontinuation of medications (especially antibiotics)
  - Notify AC clinic of dose changes of relevant medications (for example; amiodarone)
  - Notify AC clinic of any change in hepatic or renal function

Patient's Name: ______________________________________ Date: _______________________

Patient's phone number: _______________________________ **Patient's DOB:** ______________

Address: ____

INDICATION: ____

Past Medical History:

❑ Cognitive Impairment	❑ Hypertension	❑ Alcohol Abuse
❑ Peptic Ulcer Disease	❑ GI Bleeds	❑ Seizure Disorder
❑ Arthritis	❑ Hx of Falls	❑ Cancer Type:
❑ Diabetes	❑ PVD	❑ Hyper/Hypothyroidism
❑ Liver disease	❑ CHF	❑ A.fib/A.flutter
❑ Cholesterol	❑ Renal impairment/Dialysis	❑ Psychosis
❑ Hx of DVT (Date:)	❑ Hx of CVA (Date:)	❑ Hx of PE (Date:)

Other Past Medical History:

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Date Warfarin initiated: ____________**Dosage/tablet strength:** _______ **Current dose**: _________________

Date	INR	Dose

Physician responsible for interim management prior to AC clinic appointment: _________________________

Phone: ______________________________________ **Fax:** ____

Interim anticoagulation plan: ____

Is the patient receiving Low Molecular Weight Heparin injections? Yes❑ No❑

If Yes, indicate ❑ Prophylaxis **or** ❑ Therapeutic

Start date: _______________ **Dose:** _____________________________________ **Patient's weight:** __________

LAB Data: SCr ___________ Date: _______________ **Hct** ____________ Date: ______________

Anticipated Duration: ❑ life ❑ 3 months ❑ 6 months ❑ Other _____________

Target/Range: ❑ INR = 2.5 (2.0-3.0) ❑ INR = 3.0 (2.5-3.5) ❑ Other __________

Current Medications:

Is the patient currently taking any antiplatelet agent? ❑ Aspirin ❑ Dipyridamole ❑ Clopidogrel ❑ Other

Referring team to liaise with cardiology accordingly and list antiplatelet agent/s patient should stop while on Warfarin. ____

A report regarding the patient's anticoagulation status should be sent to:

1. **My office:** Phone# ______________________ Fax#_______________________ **and/or**
2. **Dr.** ________________________________Phone# ______________________ Fax#_______________________

Physician Signature: ________________________________ **Print Name**: _________________________________

Date: _______________ Time: _________________

Please provide the Primary Care Physician's Contact Information (if you are not the PCP):

Name: _________________________ **Phone#**_______________________ **Fax #**_________________________