Hallmark Health System Anticoagulation Management Service Patient Referral Form

Instructions: Please complete this referral form by filling in all requested information about the patient and fax to 781-213-5125. Upon receipt of this referral, you will receive a faxed confirmation from the clinic with the date and time of the patient's first clinic appointment. Patients will be officially enrolled into the AMS after their initial clinic visit.

Patient Demographics:

Patient Name: _____ MR:_____ DOB: _____

Address: _____ Telephone number: _____

Physician Information:

Referring physician: _____Phone #:_____ _____ Fax #:_____ _____

Primary Care Physician (If different than referring MD): _____Phone #:_____

Laboratory Information:

1. Is patient currently testing at a non-HHS affiliated laboratory. (Y/N). If yes, please indicate which lab: _____

2. Is patient receiving VNA/home draw services? (Y/N). If yes, please indicate which agency: _____

1. Indication for anticoagulation:

- ❑ Atrial fibrillation
- ❑ Atrial Flutter
- ❑ History of stroke/TIA's
- ❑ PE treatment
- ❑ DVT treatment
- ❑ History of PE/DVT
- ❑ Mechanical Mitral Valve Replacement
- ❑ Mechanical Aortic Valve Replacement
- ❑ Bioprosthetic Mitral Valve Replacement
- ❑ Antiphospholipid Syndrome
- ❑ Factor V Leiden Deficiency
- ❑ Antithrombin III Deficiency
- ❑ Protein C Deficiency
- ❑ Protein S Deficiency
- ❑ Prothrombin G20210A Mutation
- ❑ Total Knee replacement
- ❑ Total Hip Replacement
- ❑ Hip Fracture Surgery
- ❑ Other:_____

2. Date anticoagulation therapy initiated: _____

3. Target INR range:

- ❑ 1.5-2.0
- ❑ 1.5-2.5
- ❑ 2.0-2.5
- ❑ 2.0-3.0
- ❑ 2.5-3.5
- ❑ 3.0-4.0
- ❑ Other: _____

4. Anticipated duration of therapy:

- ❑ 3 months
- ❑ 6 months
- ❑ Life
- ❑ Other: _____

5. Last INR: _____ Date: _____

6. Next INR due on: _____

7. Current Warfarin Dosage and length of time on this dose: _____

8. Strength of Warfarin tablets already prescribed to patient: _____

9. Has patient had any bleeding complications while on warfarin? _____

10. Will this patient require "bridging" if warfarin needs to be held for a procedure? (Y/N)

11. Please attach a current medication list or indicate current patient medications in the space provided (drug name, dose, and directions):

12. Please provide patient medical history in the space provided below.

Physician Signature: _____ Date: _____ Time:_____

Received by: _____ Date: _____

Initial clinic visit scheduled for: _____ (Enrollment start date)