BEACON HEALTH SYSTEM

Patient Label

First Appointment Date & Time: ___________________

1. Fax **completed** Anticoagulation Clinic Patient Referral form and recent H&P to (574) 647-4220.
2. Call the Outpatient Scheduling Department at (574) 647-7700 to schedule the initial appointment.

Patient Name:	Home Phone #:
Patient Address:	Cell Phone #:
	DOB:
	Male Female
Referring Provider:	Office Phone:
Emergency Number/Pager:	Office Fax:

Physician Notification: ❑ Each INR result ❑ Each dosage change ❑ 3 month summary

Primary Indication for Warfarin				
	❑ Atrial Fibrillation	**I4891**	❑ Dilated Cardiomyopathy	**I420**
	❑ Atrial Flutter	**I4892**	❑ Transient Ischemic Attack	**G459**
	❑ Cardiac dysrhythmia, other	**I499**	❑ Cerebrovascular disease	**I679**
	❑ Acute Myocardial Infarction	**I213**	❑ DVT, Lower Extremity	**I82409**
	❑ Valve disorder, Aortic	**I359**	❑ DVT, arm	**I82629**
	❑ Valve disorder, Mitral	**I348**	❑ Pulmonary Embolism	**I2699**
	❑ Valve, Mechanical	**Z952**	❑ Other:	
	❑ Valve, Bioprosthetic	**Z953**		
	❑ Other/Longterm use of anticoagulants	**Z7901**		
	Please specify diagnosis i.e. Lupus, factor V leiden, phospholipid syndrome:			

Desired INR		**Duration of Therapy**
❑ 2 — 3	**Warfarin Dose:** ____________________	❑ Chronic/ongoing
❑ 2.5 — 3.5	Last INR: ____________ Date: ____________	❑ To end ____/____/____
❑ Other:	**Enoxaparin Dose:** ____________________	❑ Total of _____ Weeks
____________	**DOAC Name & Dose:** ____________________	❑ Total of _____ Months

Does patient take: ❑ Aspirin ❑ Ticagrelor(Brilinta) ❑ Cilostazol(Pletal) ❑ Clopidogrel(Plavix)
❑ Prasugrel (Effient) ❑ Other anticoag/antiplatelet med: ______________________________

PMH: ❑ Diabetes ❑ Stroke ❑ CNS Bleed ❑ ETOH Abuse ❑ Labile INRs
❑ GI Bleed ❑ Renal Disease ❑ Hepatic Disease ❑ Hypertension uncontrolled

By my signature below, I authorize the following actions by the Anticoagulation Clinic Pharmacist:

1. Initiate, adjust, and monitor drug therapy regimens related to the following medications in accordance with the EGH Anticoagulation Clinic dosing guidelines on file and the collaborative practice agreement with the Medical Director of the Anticoagulation Clinic, warfarin (Coumadin®), heparin, LMWH, dabigatran (Pradaxa®), apixaban (Eliquis®) and edoxaban (Savaysa®).
2. Order laboratory tests: INR, CBC w/o diff, aPTT, anti Xa level, SCr, Factor X activity, Factor II activity, Hepatic Function Panel, or any lab needed for safe anticoagulation therapy.

Provider Signature: ______________________________ Date: ______________ Time: ____________

Memorial Hospital Anticoagulation Clinic * 707 N. Michigan St Ste. 115 * South Bend, IN. 46601* *Phone #: 574-647-4202 Fax #: 574-647-4220*
Email: MHSBanticoag@beaconhealthsystem.org

578027