



First Appointment Location: EGH MHSB Date & Time: _____

1. Fax **completed** Anticoagulation Clinic Patient Referral form and recent H&P to: (574) 647-4220 (MHSB) or 574-523-3470 (EGH)
2. To schedule an appointment, call the Anticoagulation Clinic at: (574) 647-7700 (MHSB) or (574) 523-2785 (EGH)

Patient Name:		Home Phone #:		
Patient Address:		Cell Phone #:		
		DOB:		
		Male Female		
Referring Provider:		Office Phone:		
Emergency Number/Pager:		Office Fax:		
Physician Notification: <input type="checkbox"/> None (available in the eHR) <input type="checkbox"/> 3 month summary <input type="checkbox"/> Each dosage change <input type="checkbox"/> Each INR result				
Primary Indication for Anticoagulation	<input type="checkbox"/> Atrial Fibrillation	I4891	<input type="checkbox"/> Dilated Cardiomyopathy	I420
	<input type="checkbox"/> Atrial Flutter	I4892	<input type="checkbox"/> Transient Ischemic Attack	G459
	<input type="checkbox"/> Cardiac dysrhythmia, other	I499	<input type="checkbox"/> Cerebrovascular disease	I679
	<input type="checkbox"/> Acute Myocardial Infarction	I213	<input type="checkbox"/> DVT, Lower Extremity	I82409
	<input type="checkbox"/> Valve disorder, Aortic	I359	<input type="checkbox"/> DVT, arm	I82629
	<input type="checkbox"/> Valve disorder, Mitral	I348	<input type="checkbox"/> Pulmonary Embolism	I2699
	<input type="checkbox"/> Valve, Mechanical	Z952	<input type="checkbox"/> Other:	
	<input type="checkbox"/> Valve, Bioprosthetic	Z953		
<input type="checkbox"/> Other/Longterm use of anticoagulants		Z7901		
Please specify diagnosis i.e. Lupus, factor V leiden, phospholipid syndrome:				
Desired INR	Warfarin Dose: _____		Duration of Therapy	
<input type="checkbox"/> 2 — 3	Last INR: _____ Date: _____			
<input type="checkbox"/> 2.5 — 3.5	Enoxaparin Dose: _____		<input type="checkbox"/> Chronic/ongoing	
<input type="checkbox"/> Other: _____	DOAC Name & Dose: _____		<input type="checkbox"/> To end ___/___/___	
			<input type="checkbox"/> Total of _____ Weeks	
			<input type="checkbox"/> Total of _____ Months	
Does patient take: <input type="checkbox"/> Aspirin <input type="checkbox"/> Ticagrelor(Brilinta) <input type="checkbox"/> Cilostazol(Pletal) <input type="checkbox"/> Clopidogrel(Plavix)				
<input type="checkbox"/> Prasugrel (Effient) <input type="checkbox"/> Other anticoag/antiplatelet med: _____				
PMH: <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> CNS Bleed <input type="checkbox"/> ETOH Abuse <input type="checkbox"/> Labile INRs				
<input type="checkbox"/> GI Bleed <input type="checkbox"/> Renal Disease <input type="checkbox"/> Hepatic Disease <input type="checkbox"/> 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 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®), rivaroxaban (Xarelto®), 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: _____

Elkhart General Hospital Anticoagulation Clinic, 600 East Boulevard *
 Elkhart, IN 46514 * Phone #: 574-523-2785 Fax #: 574-389-4843
 email: EGHanticoag@beaconhealthsystem.org

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



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