BEACON HEALTH SYSTEM

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) 647-4202 (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: ❑ None (available in the eHR) ❑ 3 month summary ❑ Each dosage change ❑ Each INR result

Primary Indication for Anticoagulation

❑ 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
- ❑ 2 — 3
- ❑ 2.5 — 3.5
- ❑ Other: _____

Warfarin Dose: _____

Last INR: _____ Date: _____

Enoxaparin Dose: _____

DOAC Name & Dose: _____

Duration of Therapy
- ❑ Chronic/ongoing
- ❑ To end ____/____/____
- ❑ Total of _____ Weeks
- ❑ 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 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

Form # 578027 M (Rev. 09/2020)
Anticoagulation Clinic
Patient Referral/Order Form

578027