Elkhart General Hospital
BEACON HEALTH SYSTEM Care Partner

Anticoagulation Clinic
Patient Referral/Order Form
First Appointment Date: _____

1. Fax completed Anticoagulation Clinic Patient Referral form and recent H&P to 574-523-3470.
2. Call the Anticoagulation Clinic at 574-389-4864 to schedule the initial appointment

Patient name:	Phone Home: Cell:
Patient Address:	DOB:
	Male Female
Referring Physician:	Office Phone:
Emergency Number/Pager:	Office Fax:
Physician Notification: □ Each INR result □ Each dosage change □ 3 month summary	

Primary Indication for Warfarin	□ Atrial Fibrillation 427.31, I4891	□ Dilated Cardiomyopathy 425.4, I420
	□ Atrial Flutter 427.32, I4892	□ Transient Ischemic Attack 435.9, G459
	□ Cardiac dysrhythmia, other 427.9, I499	□ Cerebrovascular disease 437.9, I679
	□ Acute Myocardial Infarction 410.92, I213	□ DVT, Lower Extremity 453.4, I82409
	□ Valve disorder, Aortic 424.1, I359	□ DVT, arm 453.82, I82629
	□ Valve disorder, Mitral 424.0, I348	□ Pulmonary Embolism 415.19, I2699
	□ Valve, Mechanical V43.3, Z952	□ Other _____
	□ Valve, Bioprosthetic V42.2, Z953	_____
	□ Other/Longterm use of anticoagulants V58.61, Z7901 Please specify diagnosis i.e. Lupus, factor V leiden, phospholipid syndrome:	

Desired INR		**Duration of Therapy**
□ 2 – 3 □ 2.5 – 3.5 □ Other _____	**Warfarin dose:**_____ Last INR:_____ Date: _____ **Enoxaparin Dose**:_____ **DOAC Name & Dose:**_____	□ 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 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®), 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, HFP, any lab needed for safe anticoagulation therapy

Physician/Prescribing Practitioner Signature: _____
Date: _____Time:_____

10/2015