Anticoagulation Clinic
423 N. Third Avenue, Suite 110
Sandpoint, ID 83864
Phone: 208-255-4101
Fax: 208-255-4102

Patient is referred for long-term anticoagulation therapy. Patient is: (choose one)

- ❑ New patient to warfarin (Coumadin)
- ❑ New thrombotic event while on warfarin therapy
- ❑ New hemorrhagic event (bleed or INR > 6 on admit) due to warfarin
- ❑ Established on warfarin therapy (on warfarin > 1 month)

Patient Eligibility:

- PATIENT MUST BE ABLE TO TRAVEL TO AND FROM CLINIC FOR APPOINTMENTS.
- Patient must demonstrate capability for self-administration of warfarin or have a caretaker who can supervise the medication.
- Patient must have a telephone or reliable 24-hour a day, 7-day a week contact established.
- Patient must have a local primary care provider.

Patient Information:

Name:	DOB:	Age:
Address:		Sex:
Insurance	Phone:	

Indication for Anticoagulation: **Warfarin Start Date:** _____

❑ Atrial Fibrillation	❑ Pulmonary Emboli	❑ Acute ❑ Chronic
❑ Atrial Flutter	❑ Deep Vein Thrombosis (DVT)	❑ Acute ❑ Chronic *Location:_____
❑ Coronary Artery Disease (CAD)	❑ Acute Myocardial Infarction (AMI)	*Date:_____
❑ S/P CVA (stroke)	❑ Mechanical Heart Valve	❑ Aortic ❑ Mitral
❑ S/P TIA (transient ischemic attack)	❑ Bioprosthetic Heart Valve	❑ Aortic ❑ Mitral
❑ Peripheral Vascular Disease	❑ S/P THR (Total Hip Replacement)	*Date:_____
❑ Hypercoagulable Disorder	❑ S/P TKR (Total Knee Replacement)	*Date:_____
❑ Other:	❑ S/P HFS (Hip Fracture Surgery)	*Date:_____

Target INR:

INR Goal Range:	**Treatment Duration:**		
❑ 2 – 3	❑ 4 weeks	❑ 3 months	❑ 35 days/ Ortho DVT prophylaxis
❑ 2.5 – 3.5	❑ 6 months	❑ 1 year	❑ Lifetime
❑ Other:	❑ Cardioversion (dates per MD)		❑ Other:

If other indicated, please enter an estimated duration (i.e. cardioversion: 7+weeks) or goal range other than listed.

Patient Label

Patient Referral

P O . W R I T T E N

Anticoagulation History (if applicable)

Currently on LMWH or heparin? ❑ Yes or ❑ No

Dose: _____ Date started: _____

Current Daily Warfarin Dose: _____

Most Recent INR/PT & Date: _____

History of bleed of thromboembolic event while on warfarin? _____

_____

_____

Physician information:

Referring physician/specialty (please print): _____

Office #: _____ Fax #: _____

Primary physician (if not referring physician): _____

Please include most recent history and physical, progress notes, home medications, allergies, date and result of last PT/INR.

Desired date of first Anticoagulation Clinic visit (closed weekends/holidays): _____

I authorize the clinical pharmacists at Bonner General Health Anticoagulation Clinic to order and perform PT/ INR testing, make anticoagulant dosage adjustments, order prescription refills for anticoagulants as appropriate, and provide anticoagulation education according to P&T approved Anticoagulation Clinic Policy and Procedures.

_____ _____ _____

Physician Signature *Date* *Time*

Every attempt will be made to schedule the patient as soon as possible. The physician is responsible for management of the anticoagulant therapy until the patient can be seen at the Bonner General Health Anticoagulation Clinic.

Fax completed referral to: **208-255-4102**, OR call the Anticoagulation Clinic for an appointment at **208-255-4101.**

Patient Label

Patient Referral

P O . W R I T T E N