



Anticoagulation Clinic

520 N. 3rd Ave
 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: _____

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

Target INR:

INR Goal Range:	Treatment Duration:
<input type="checkbox"/> 2 – 3	<input type="checkbox"/> 4 weeks <input type="checkbox"/> 3 months <input type="checkbox"/> 35 days/ Ortho DVT prophylaxis
<input type="checkbox"/> 2.5 – 3.5	<input type="checkbox"/> 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> Lifetime
<input type="checkbox"/> Other:	<input type="checkbox"/> Cardioversion (dates per MD) <input type="checkbox"/> Other:

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

Patient Label

Patient Referral

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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 referrals to: 208-255-4102 Or
Call the Anticoagulation Clinic for an appointment at: 208-255-4101

Patient Label

Patient Referral

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