Patient Identification

Frederick Memorial Hospital
400 West 7th Street
Frederick, MD 21701
Phone: 240-566-3940 Fax: 240-566-3197

Anticoagulation Service Referral Form

Referral Process: Clinicians please complete this referral form completely with all requested patient information. Fax the form to the anticoagulation Service at 240-566-3197. Please inform the patient that the anticoagulation Service personnel will contact them for a follow up appointment if one has not already been made.

Patient's Name: _____ ***Date:*** _____

Phone #: _____ ***Date of Birth:*** _____

Diagnosis and Indication for anticoagulation therapy:

- ☐ Anterior MI
- ☐ Antiphospholipid Antibodies
- ☐ Atrial Fibrillation
- ☐ Atrial Flutter
- ☐ CVA/TIA
- ☐ Cardiolipid Antibodies
- ☐ Dilated Cardiomyopathy
- ☐ DVT 1st episode
- ☐ DVT recurrent or high risk
- ☐ Indwelling Subclavian Catheterization
- ☐ PE 1st episode
- ☐ PE recurrent or high risk
- ☐ Peripheral Arterial disease
- ☐ Peripheral Vascular Disease
- ☐ Prosthetic Heart Valve (type & location): _____
- ☐ Protein C or S Deficiency
- ☐ Other: _____

HPI: Indicate pertinent physical findings

Past medical history (PMH):

- ☐ Heart failure
- ☐ Peptic ulcer disease
- ☐ Arthritis
- ☐ IV drug/alcohol abuse
- ☐ Other PMH: _____
- ☐ Hypertension
- ☐ GI Bleed
- ☐ Fall history
- ☐ Cognitive impairment
- ☐ Diabetes mellitus
- ☐ Seizure disorder
- ☐ Cancer (type:
- ☐ Pregnancy (Due date

Social History: ☐ Lives alone ☐ Smoker ☐ Vegetarian

Date anticoagulation therapy initiated: _____ Initial dose: _____ Current dose: _____

Most recent lab results: INR: _____ Date: _____ Hemoglobin/hematocrit: _____ Date: _____

Anticoagulation prescription: ☐ Warfarin ☐ Heparin ☐ Enoxaparin ☐ Fondaparinux (Arixtra) ☐ Other: _____

Duration of therapy: ☐ Life ☐ 3 months ☐ 6 months ☐ Other _____

Goal INR: ☐ INR = 2-3 ☐ INR = 2.5-3.5 ☐ Other: _____

Current medications:

May the patient take low dose aspirin if indicated: ☐ Yes ☐ No

I give my authorization for FMH Anticoagulation Clinic to monitor and adjust the dosage of warfarin in this patient based on established protocols, policies and procedures and may also act as my agent in renewing prescriptions for anticoagulation medication if needed. Reports of all patient visits to the Anticoagulation Service will be faxed to your office to update you on the patient's anticoagulation status.

Physician's Signature/Mneumonic: _____ **Date/Time:** _____

Printed Name: _____

Physician office phone: _____ **Office FAX #:** _____