PROVIDENCE
Sacred Heart Medical Center
Sacred Heart Children's Hospital
Holy Family Hospital

DATE: ____________________

TO: ____________________ **FAX:** ____________________

TO: ____________________ **FAX:** ____________________

❑ **FROM:** Providence Holy Family Anticoagulation Clinic ____________________
(Pharmacist Printed)

TELEPHONE: (509) 482–3057 **FAX:** (509) 482–3058

❑ **FROM:** Providence Sacred Heart Medical Center Anticoagulation Clinic ____________________
(Pharmacist Printed)

TELEPHONE: (509) 474–2232 **FAX:** (509) 474–2233

COMMENTS: Attached is a courtesy copy of the proposed LMWH bridge plan for your patient.

Please contact us immediately if you would like any modifications to this plan.

CONFIDENTIALITY STATEMENT

Protected Health Information (PHI) and/or other confidential information may be included in this fax. Because of the sensitive nature of such information, your are obligated to maintain the information in a safe, secure and confidential manner. Re–disclosure without additional consent maybe prohibited.

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For internal use: Please forward this form to the HIM Dept. if the information was sent to public health agencies; FDA; employer for medical surveillance, work related injury, OSHA; healthcare oversight agencies; judicial & administrative proceedings pursuant to court order; law enforcement agencies pursuant to a court order; disclosures on behalf of the deceased to medical examiner, funeral director, or as related to organ procurement; specialized government function; research; worker's compensation; state health commission' US Embassies, Business Associates & vendors requires tracking in accordance w/HIPAA regulations.

Bridge Therapy Plan & Instruction Sheet

❑ Sacred Heart Anticoagulation Clinic
104 W. 5th Ave., Suite 112W
Spokane, WA 99204
Phone: 509.474.2232
Fax: 509.474.2233

❑ Holy Family Anticoagulation Clinic
46 E. Rowan
Spokane, WA 99208
Phone: 509.482.3057
Fax: 509.482.3058

Patient

NAME:
DATE OF BIRTH:
MR:

Anticoag DX: ____________________

INR Range: ____________________

Procedure: ____________________ ____________________
Date/Time

Justification to hold warfarin

❑ Invasive procedure ❑ Per MD request ❑ Other: ____________________

Justification for bridge therapy

❑ $CHADS_2$ >2
❑ Prosthetic heart valve
❑ Acute VTE < 3 mo ago
❑ Mitral valve disease
❑ CVA/TIA < 6 mo ago
❑ Other ____________________
❑ High risk thrombophilia(s)

Labs/Risk

Date	Scr (mg/dl)	Hct (%)	Plt (K/ul)

	Date	Score	Rate
Afib $CHADS_2$[1]			%
OBRI[2]			%
Afib bleed risk[3]			%

1. National registry of Atrial fibrillation (NRAF) participates (Gage BF et al. JAMA 2001; 285:2864–70)
2. Outpatient bleeding risk (OBR) (Beyth RJ, 1998)
3. Shireman et al, CHEST 2006

Has patient had unfractionated heparin in last 100 days? (Circle one) Y N Unclear

If yes/unclear: Order platelets 24 hr after dose and every 3–5 days while on injections

Is patient on ASA or other anti–platelet medications? (Circle one) Y N Meds: ____________________

❑ Continue

❑ D/C ________ days prior and patient notified.

Patient Weight: ______________ kg

Estimated CrCl ____________________ml/min

Patient Height: ______________ feet/inches

❑ Office
❑ Self Report

Rx
❑ Enoxaparin______mg SC Q12hr
❑ Enoxaparin______mg SC Q24hr
❑ Dalteparin ______ units SC Q24hr
❑ Other ____________________

❑ Rx given to pt ❑ Rx Called

Pharmacy ______________________________ Ph ____________________ Quantity __________________syringes

Usual Warfarin Dose/Direction: Warfarin __________mg Sig: ____________________

Yes	No	**Patient/caregiver states has been previously trained and comfortable with administering injections**
Yes	No	**Patient unable or unwilling to self–administer injections**

Pharmacist:______________________________ Date/Time: ____________________

(label)

ACC

Bridge Therapy Patient Instruction Sheet

Day of Week	Date	Injection Administration Time ________________________ Med/dose Inject subcutaneously every _______ hours (time)		Coumadin Dose: ___**mg tablets** Daily in the **evening**	Appointment Followup or Labs
–7/		**AM**	**PM**	**TABS**	
–6/		**AM**	**PM**	**TABS**	
–5/		**AM**	**PM**	**TABS**	
–4/		**AM**	**PM**	**TABS**	
–3/		**AM**	**PM**	**TABS**	
–2/		**AM**	**PM**	**TABS**	
–1/		**AM**	NONE	**TABS**	
0/ Date	Day	NONE	NONE	**TABS**	
Procedure Type	Time				
1/		**AM**	**PM**	**TABS**	
2/		**AM**	**PM**	**TABS**	
3/		**AM**	**PM**	**TABS**	
4/		**AM**	**PM**	**TABS**	
5/		**AM**	**PM**	**TABS**	
6/		**AM**	**PM**	**TABS**	
7/		**AM**	**PM**	**TABS**	
8/		**AM**	**PM**	**TABS**	

Follow the above bridge instructions unless your surgeon or procedure doctor states otherwise. If so, follow your surgeon's instructions or procedure doctor's instructions.

***Attention MD**: Courtesy copy sent for your records. If questions or concerns, please contact*
❑ ***PHFH Anticoagulation Clinic at 509–482–3057.*** ❑ ***SHMC Anticoagulation Clinic 509–474–2232***

Pharmacist:____ Date/Time: ________________________

(label)