□ MR#:	**UW HOSPITAL & CLINICS**	□ REFERRALS MUST BE MADE BETWEEN 8:30 - 4:30PM MON. THRU FRIDAY
□ NAME:	**ANTICOAGULATION SERVICE**	□ CALL 263-8475 **OR** PAGE #7206 TO START PROCESS
□ DOB:	**REFERRAL FORM**	□ LAB ORDERS MUST BE SET UP PRIOR TO DISCHARGE
□ UNIT:	**FOR INPATIENTS**	□ FACE SHEET MUST BE FAXED TO 263-8027 UPON DISCHARGE

REFERRRING PHYSICIAN: Please complete this section, sign, and then forward to case manager.

ν INDICATION FOR WARFARIN TREATMENT (TX):

□ DVT/PE PREVENTION *reason*_____

□ RECURRENT DVT/PE *location(s)*_____

□ HEART VALVE REPLACEMENT *location/type*_____

□ AFIB
□ TIA(S)
□ STROKE(S) *location/type*_____

□ COAGULOPATHY *type*_____

□ DVT/PE TREATMENT *location(s)*_____

□ SYSTEMIC /RECURRRENT EMBOLISM *location(s)*_____

□ CARDIOMYOPATHY
□ MITRAL STENOSIS

□ OTHER_____

ν TARGET INR: □ 2.0 – 3.0 (ie, Afib, stroke, DVT/PE prevention, DVT/PE treatment, Bioprosthetic valves in mitral/aortic position, St. Jude, Carbomedics, Medtronic Hall in aortic position)
□ 2.5 – 3.5 (ie, tilting disk valves & bileaflet mechanical valves in mitral position, recurrent thrombosis)

ν ANTICIPATED DURATION OF TX: □ INDEFINITE □ 3 MONTHS □ 6 MONTHS □ OTHER _____

ν WILL THIS PATIENT REQUIRE LMWH OR IV HEPARIN TO "BRIDGE" FOR PROCEDURES REQUIRING HIM/HER TO BE OFF WARFARIN (colonoscopy, surgery, etc): □ YES □ NO

ν REFERRING MD SIGNATURE/PAGER# _____

CASE MANAGER: Please call to start the referral process. Then complete this section, sign, & fax to 608-263-8027.

ν **PLEASE VERIFY THAT THIS PATIENT MEETS THE FOLLOWING ANTICOAGULATION SERVICE CRITERIA:**
- □ Patient MUST have a UW Primary Care Physician
- □ Patient MUST be willing to come to the Anticoagulation Clinic for scheduled Point-of-Care appointments in Madison (West Clinic or University Station)
- □ Patient CANNOT have Dean or Group Health Cooperative as primary insurance
- □ Patient CANNOT reside in a nursing home or long-term care facility

ν EXPECTED DATE OF DISCHARGE_____

ν DISCHARGE TO WHAT LOCATION_____PHONE#_____

ν **FOR ORTHOPEDIC PATIENTS ONLY**: WILL A HOME HEALTH AGENCY BE INVOLVED ? □ YES □ NO

*IF YES, WHICH AGENCY*_____*PHONE #*_____

*IF NO, WHICH LAB WILL THE PATIENT GO TO*_____*PHONE #*_____

ν WHEN WILL 1ST INR BE DRAWN_____

ν FREQUENCY OF INR TO BE DRAWN THE 1ST WEEK_____

ν CASE MANAGER SIGNATURE/PAGER #_____

ν SPECIAL CONCERNS/INSTRUCTIONS: