Capital Health

Physician Referral Form
Pharmacy Department
Department of Medicine/Division of Hematology

# Anticoagulation Clinic Referral Form

Patient: _____

Patient Phone Number: _____
(Include number with an answering machine)

Date (YYYY/MM/DD): _____ Time 24hr (hh:mm): _____

**REFERRED FROM:**

In-Patient Unit ☐ Yes ☐ No Specify Unit: _____

Clinic ☐ Yes ☐ No Specify Clinic: _____

**INDICATION FOR ANTICOAGULANT THERAPY:** (Please check the appropriate indication)

- ☐ Deep Venous Thrombosis/Pulmonary Embolism
- ☐ Atrial fibrillation
- ☐ Cardiomyopathy
- ☐ Valvular heart disease
- ☐ Tissue Heart Valve
- ☐ Mechanical Prosthetic Valve
- ☐ Recurrent Systemic Embolism
- ☐ Other (specify) _____

**COMMENTS:**
(Include recent warfarin dosages, INRs, date of next INR or any specific concerns)

**Please fax to Anticoagulation Clinic along with Patient Interim Discharge Summary at 473-6812.**

| Date (YYYY/MM/DD) | Physician's Signature | Physician's Name - Print | Pager Number |
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