Updated 10/21/2015

Indian River Medical Center

Anticoagulation Management Clinic Referral

Please fax this form to: 772-794-1487 or 772-564-6787 (Pointe West)

Patient Name (last, first): _____ **Date:**_____

Phone #:_____ **DOB:** _____

Referring Physician Signature:_____

Physician Printed Name:_____

MD Phone: _____ **MD Fax:** _____

The following items MUST be completed by physician for enrollment:

1. Indication (Please indicate date of DVT/PE if applicable):

□ **DVT I82.91** □ **PE I26.99** □ **A fib I48.91** □ **Other:**_____

□ **Mitral Valve Replacement I34.8, Z95.2** □ **Aortic Valve Replacement I35.9, Z95.2**

□ **CVA I67.9** □ **Hypercoaguable State (please list):** _____

2. When Coumadin Started: _____ **Current dose:**_____

3. Patient's Last INR: _____ **(date:**_____**)** **Date Patient due for next INR:** _____

4. Desired INR: □ **2-3** □ **2.5-3.5** □ **other**_____

5. Duration of Therapy: □ **3 months** □ **6 months** □ **Indefinite** □ **other**_____

6. Therapeutic Bridging (optional): Dose is weight based on indication per clinic protocol

□ **Arixtra subcutaneously daily until 2 consecutive therapeutic INRs**
□ **Lovenox subcutaneously daily until 2 consecutive therapeutic INRs**
□ **Other** _____

7. Please indicate location patient would prefer (optional):

□ **IRMC Main Campus** □ **Pointe West** □**Sebastian**

By utilizing this form, it is assumed that you have read and agreed to the AMC Policies and Procedures. Please contact AMC if you have not seen the policies and procedures and would like them faxed to you. A clinical pharmacist can be reached at 772-563-4611 or ext 1773. Pointe West clinic please call 772-226-4260, Sebastian 772-226-3773.