Anticoagulation Management Clinic Referral

Please fax this form to: 772-794-1487

Patient Name (last, first):	DOB:	Phone #:
Preferred Clinic Location: ☐ IRMC Main Campus	☐ Pointe West	☐ Sebastian

The following items MUST be completed by provider for enrollment

Please complete the appropriate boxes and sign and date below.

Please fax back referral, along with demographic information and last progress note.

Indication for warfarin therapy:

Atrial Fibrillation	☐ Paroxysmal (I48.0)	☐ Persistent (I48.1)	☐ Chronic (I48.2)
Atrial Flutter	☐ Typical (I48.3)	Atypical (I48.4)	
DVT (chronic embolism & thrombosis)	**Lower extremity** ☐ Right lower extremity (I82.501) ☐ Left lower extremity (I82.502) ☐ Bilateral (I82.503)	**Upper Extremity** ☐ Right upper extremity (I82.721) ☐ Left upper extremity (I82.722) ☐ Bilateral (I82.723)	
PE	☐ Chronic PE (I27.82)		
Valve Replacement	**Mitral** (Z95.2) ☐ Bioprosthetic ☐ Mechanical	**Aortic** (Z95.2) ☐ Bioprosthetic ☐ Mechanical	☐ TAVR (Z95.2)

☐ **Cerebrovascular Accident** (I67.9)

☐ **Hypercoagulable state (please list):**

☐ **Other** (please write in indication, along with appropriate ICD-10 code):

Desired INR Goal:

☐ 2-3	☐ 2.5-3.5	☐ Other (please specify range):

Duration Of Therapy:

☐ 3 months	☐ 6 months	☐ Indefinite	☐ Other (please specify duration):

Additional Information:

When was Coumadin started?	What is patient's current dose?	When is next INR due?

What was patient's last INR and when was it drawn? INR: _________ (date: ________)	Is therapeutic bridging needed (if yes, indicate below)? ☐ Yes: Lovenox ☐ Yes: Arixtra *Dosing based on weight/indication and per clinic protocol
Referring Provider Ph #:	**Referring Provider Fax #:**

Referring Provider: **(**must be signed in order for referral to be valid and complete**)**	➢ _____________________________ **(signature)** ____________ **(date)** ➢ _____________________________**(printed name)**

	➢ ______________________________(provider NPI number)

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.