Memorial
Hospital & Health System℠

ANTICOAGULATION CLINIC
REFERRAL AGREEMENT

Date ___________________________

Dear Dr. _________________________________:

By signing this form, you are accepting the clinic's management methods and authorize the pharmacist to work with your patient(s) to obtain the best possible outcomes via dosage adjustment, laboratory monitoring and extensive patient education. Dr. Thomas Troeger, MD is the medical director of the anticoagulation clinic and will be overseeing care.

___ Yes ___ No I agree with the clinic protocols.

___ Yes ___ No I authorize the clinic to act as my agent and communicate a standing order for laboratory monitoring involved with anticoagulation (INR).

___ Yes ___ No I authorize the clinic to act as my agent and communicate necessary warfarin refills for the anticoagulation.

If no is checked for any of the above, the respective duty remains with the prescribing physician and agent representation is denied.

Please identify additional physicians with which you wish this information to be shared.

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The physician will inform the Anticoagulation Clinic of any medical status or medication changes and laboratory results whenever possible.

_______________________________________ _______________
Physician Signature Date

Please return to: **Memorial Outpatient Anticoagulation Clinic**
Health Discovery Center – Suite 6670
100 Navarre Pl
South Bend, IN 46601
Phone: 574-647-1990
Fax: 574-647-1314