Memorial
Hospital & Health System℠

OUTPATIENT ANTICOAGULATION CLINIC

PATIENT INFORMATION REFERRAL FORM

Date ______________________

Referring Physician: _________________________________ Office Phone: ____________________
Fax: ____________________________ Emergency Number / Pager: ___________________________

I. PATIENT DEMOGRAPHICS

Patient Name: ____ SSN: ________________________
DOB: _________________ Gender: _____________ Phone Number: _________________________
Address:____

II. PHYSICIAN NOTIFICATION (Choose one)

[ ] Each INR Result   [ ] Each dosage change   [ ] Six month summary

III. INDICATION FOR ANTICOAGULATION please circle indication(s)

Atrial Fibriliation: Chronic New Onset	**Dilated Cardiomyopathy**	**Prosthetic Valve**: Mitral Aortic Pulmonic Mechanical Bioprosthetic
Acute Myocardial Infarction	**DVT**: 1st time Recurrent Location (circle) Right/Left LE/UE	**Pulmonary Embolism**: 1st time Recurrent
DVT Prophylaxis	**Graft Patency**	**Cerebrovascular Disease**: TIA Stroke
Other:		

IV. GOALS/PLAN

Goal INR:
[ ] 2-3
[ ] 2.5 – 3.5
[ ] Other, specify: ________________

Anticoagulation start date:_____________

Duration of Anticoagulation
[ ] 1 month
[ ] 3 months
[ ] 6 months
[ ] Long Term
[ ] Other: _________________________

V. RECENT HISTORY

Current daily dose ____________________
Latest INR ______________________
Date: _______________
Previous INR ____________________
Date: _______________
Latest HBG/Hct _________________
Date: _______________
Bleeding episodes Yes No
LFT's: [ ] normal [ ] elevated

Please include a recent patient H&P

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