Saint Francis Hospital
and Medical Center
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Hartford, CT 06105

ANTICOAGULATION SERVICE REFERRAL ORDER SHEET

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EFF: 3/15

Please print legibly, fill in ***ALL*** information and FAX form to the Anticoagulation Service (860)714-7598

Demographics

Patient Name:_____ **MRN:**_____

DOB:_____ **Phone (Required):**_____**Cell Phone:**_____ **Requires Interpreter: Yes/No**

Address:_____**City:**_____ **State:** ____ **Zip:**_____

Additional Contact Info:_____

Diagnosis/Indication for Anticoagulation Therapy: (Circle ALL that Apply)

- ☐ Atrial Fibrillation/427.31
- ☐ Atrial Flutter/427.32
- ☐ Acute Myocardial Infarction/410.92
- ☐ Heart Valve Replacement, mechanical/V43.3
  Type/Date:_____
- ☐ Heart Valve Replacement, human or animal/V42.2
  Type/Date:_____
- ☐ Deep Vein Thrombosis/453.9
- ☐ Pulmonary Embolism/415.19
- ☐ Cerebrovascular Accident/437.9
- ☐ Transient Ischemic Attack/435.9
- ☐ Thrombophlebitis/451.9
- ☐ Post-thrombotic Syndrome/459.1
- ☐ Hypercoagulable State/289.81
- ☐ Other:_____

Does this patient have an **IVC filter?** (Circle one) NO YES, Date Placed: _____

If indication is **atrial fibrillation**, is a cardioversion/ablation anticipated: NO YES, Procedure Date_____

Primary Medical History: (Circle ALL that Apply)

Heart Failure	Hypertension	Diabetes Mellitus	Peptic Ulcer Disease	Hx GI Bleeds
Seizure Disorder	Hx of Falls	Arthritis	CNS Bleed	Cognitive Issues
Labile INRs	ETOH Abuse	IVDA	Renal Disease	Hepatic Disease
Cancer-Type:_____		Other:_____		

Anticoagulation History/Treatment:

Anticoagulation Start Date: _____ Last INR/Date: _____Current Warfarin Dose: _____

Anticoagulant: (Circle Applicable) Warfarin Heparin Lovenox Arixtra Xarelto Other: _____

Anticipated Duration: (Circle One) 3 Months 6 Months Lifelong Other:_____

INR Goal: (Circle One) INR = 2.0-3.0 INR = 2.5-3.5 Other INR Range:_____

Physician Information:

Referring MD-Print Name:	Phone:	Fax:

Primary Care Physician (if different from Referring MD):

- ✓ **Anticoagulation Service to monitor INR and dose warfarin**
- ✓ **INR, CBC w/o diff, aPTT, anti Xa level, SCr as ordered by the Anticoagulation Service Medical Director in accordance with the Collaborative Practice Agreement, clinical protocols, and applicable standards of care.**

Referring Physician Signature: _____**Date:**_____