UPMC LIFE CHANGING MEDICINE

UPMC Western Maryland Center for Clinical Resources
Outpatient Anticoagulation Clinic
New Patient Referral Form

Date: _____ Patient Name: _____ DOB: ___/___/_____

Address: _____ Phone: ____-____-____

Referring Provider: _____ Phone: ____-____-____ Fax: ____-____-____

Primary Care Physician: _____

Indication for Anticoagulation Therapy *(check all that apply)*: ****MUST INCLUDE ICD-10 CODE****

☐ Acute DVT **ICD**:	☐ DVT Prophylaxis s/p THR **ICD**:	☐ A-fib **ICD**: I48.91
☐ Recurrent DVT **ICD**:	☐ DVT Prophylaxis s/p TKR **ICD**:	☐ S/p Stent **ICD**:
☐ Acute PE **ICD**	☐ DVT Prophylaxis s/p Fx. Hip **ICD**:	☐ Heart Valve (Aortic) **ICD**:
☐ Recurrent PE **ICD**:	☐ Stroke Prophylaxis/TIA **ICD**:	☐ Heart Valve (Mitral) **ICD**:
☐ Hypercoagulable State **ICD**:	☐ Systemic Thrombus **ICD**:	☐ Other **ICD**:

Recommended INR Range:

☐ 2.5 (2.0 – 3.0) ☐ 3.0 (2.5 – 3.5)

For any other desired INR ranges the referring provider **MUST** first speak with the clinic director, Dr. Haas, before this can be approved.

Expected Duration of Anticoagulation Therapy: **Start Date**: _____

☐ 1 Month ☐ 3 Months ☐ 6 Months ☐ 12 Months

☐ Lifelong/Indefinitely ☐ Other: _____

Current Therapy/Follow-up/Bridging: **D/C Lovenox when INR > _____**

Current Warfarin Dose: _____ Last INR Results: _____ on date: _____

Follow-Up: ☐ Immediately ☐ 1 Week ☐ 2 Weeks ☐ 3 Weeks ☐ 4 Weeks

☐ I authorize the UPMC Western Maryland Outpatient Anticoagulation Clinic to monitor, make adjustments to, and prescribe my patient's anticoagulation therapy as outlined in the Outpatient Pharmacy Anticoagulation Monitoring/Management Policy 7300.111 (Available upon request). I agree that the AC Clinic Staff may determine if patient will require bridging therapy if off of Warfarin for procedures.

Provider signature: _____ Date: _____

Patients **cannot be scheduled for appointments until** referral form is completed. Please **fax to 240-964-8687**