Dear Physician, An audit of the Anticoagulation Clinic charts has shown that for this patient a COC/Continuation of Care form is required for future service dates. Please sign & complete this form so that we will be compliant and can continue to monitor the patient. Thanks in advance for your cooperation in this matter. Sincerely, WMHS ACC Staff

Patients will be referred back to your office if there is no current Continuation of Care on file.

WMHS – Outpatient Anticoagulation Clinic

Phone: 240-964-8064 Fax: 240-964-8065

Continuation of Care Form

Patient Demographics ____

____

____

Referring Physician: ____________________ **PCP**: ____________________

Insurance: ☐ Medicare ☐ Blue Cross ☐ Other:______________________

Indication/Diagnosis for Anticoagulation (check all that apply)

☐ DVT (☐ new or ☐ recurrent) ☐ Mechanical Heart Valve (☐ Mitral or ☐ Aortic) ☐ Atrial Fibrillation

☐ Stroke Prevention/TIA ☐ Cardiomyopathy ☐ S/P Stent

☐ PE (☐ new or ☐ recurrent) ☐ Hypercoagulable State ☐ S/P MI ☐ Systemic Thrombus

☐ DVT Prophylaxis (☐ S/P THR ☐ S/P TKR ☐ S/P Fx Hip) ☐ Other: ____________________________

Duration of Therapy: ____________________________ ☐ weeks ☐ months ☐ indefinitely

Target INR Range:

☐ 2.0-3.0 ☐ 2.5-3.5 ☐ 1.6-2.2 ☐ 1.8-2.5 ☐ Other: ____________________

Current Warfarin dose in Milligrams

Date	INR	Sun	Mon	Tues	Wed	Thurs	Fri	Sat

X AC Clinic Staff may renew Warfarin prescriptions to patient's pharmacy as per ACC prescription policy

☐ Patient will need bridging therapy if off Warfarin for procedures

Physician signature ____ Date: ________________________

Patients cannot be scheduled for appointments until referral form is completed. Please fax to **240-964-8065**