WESTERN MARYLAND HEALTH SYSTEM
CENTER FOR CLINICAL RESOURCES

WMHS Center for Clinical Resources
Outpatient Anticoagulation Clinic
P: 240-964-8787 F: 240-964-8687

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 WMHS 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**