

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 The	apy (check all that	t apply): ** <mark>MUST INCLUDE IC</mark>	CD-10 CODE**	
☐ Acute DVT <u>ICD</u> : ☐ DVT Prophy		axis s/p THR <u>ICD</u> :	☐ A-fib <u>ICD</u> : I48.91	
□ Recurrent DVT <u>ICD</u> : □ DVT Prophy		axis s/p TKR <u>ICD</u> :	☐ S/p Stent <u>ICD</u> :	
☐ Acute PE <u>ICD</u>	☐ 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 Th		ombus <u>ICD</u> :	□ Other <u>ICD</u> :	
Recommended INR Range: 2.5 (2.0 – 3.0)	(=:0 0:0)	For any other desired INR rar speak with the clinic director, Start Date:	Dr. Haas, before this	
□ 1 Month □ 3 Months		☐ 6 Months	☐ 12 Months	
☐ Lifelong/Indefinitely ☐ Oth	er:			
Current Therapy/Follow-up/Bridgin	<u>g</u> :	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 M prescribe my patient's anticoagulation Monitoring/Management Policy 7300 patient will require bridging therapy if	n therapy as outline 111 (Available upo	ed in the Outpatient Pharmacy on request). I agree that the Al	Anticoagulation	·
Provider signature:		Date:		