



**Anticoagulation Services
Request for Services Form**

Patient Name _____
 Patient Phone # _____
 MR # _____ SS # _____
 DOB _____ M / F

Date: _____

Questions? Please call: **Physicians Pavilion II** Phone: 443-643-3232 Fax: 443-643-3299
Harford Memorial Hospital Phone: 443-843-5570 Fax: 443-843-5563

Services to be performed at: Physicians Pavilion II Harford Memorial Hospital

Referring Physician: _____

Primary Medical Provider: _____

Please attach patient's most recent H&P with updated problem list, medication list, and pertinent labs (CBC, Chem7 and most recent INR).

Indication for anticoagulation therapy:

- | | | |
|--|---|---|
| <input type="checkbox"/> Aortic Valve Replacement
Valve Type: _____ | <input type="checkbox"/> Antiphospholipid Antibody Syndrome | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Mitral Valve Replacement
Valve Type: _____ | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Cerebrovascular Accident (CVA) | <input type="checkbox"/> Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> Atrial Flutter | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Other _____
(diagnosis code required) |
| | <input type="checkbox"/> Deep Vein Thrombosis | |
| | <input type="checkbox"/> Mural Thrombus | |

Duration: Life 3 Months 6 Months Other _____(Specify)

Goal: INR = 2 – 3 INR = 2.5 – 3.5 Other _____(Specify)

Date Coumadin Started: _____ Current Dose of Coumadin: _____

Most Recent INR Result and date: _____

If patient is currently on low-dose aspirin therapy (81 – 325 mg) do you want to continue this therapy?

- Yes No

Urgency: High (in a few days) Moderate (in 1-2 weeks) low (next available)

Should an appointment not be available by the date requested, you will be informed to continue monitoring the patient until an appointment can be arranged.

This referral gives the Upper Chesapeake Health Anticoagulation Services (UCH ACS) authority to monitor and adjust the dosage of the above anticoagulant in this patient, based on UCH Medical Executive Committee-approved protocols, policies and procedures by pharmacists, under my oversight. The UCH AC Services pharmacist may also act as my agent in renewing prescriptions, or changing the dosage of prescriptions for the monitored anticoagulant; and may order additional pertinent labs or administer oral Vitamin K, if necessary. I understand that monitoring reports of all patient visits to the AC service will be provided quarterly, unless otherwise requested.

Physician's Signature: _____ **Print Name:** _____

Physician Office #: _____ **Office Fax #:** _____

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