INTEGRIS Anticoagulation Clinics
Patient Referral Form

INTEGRIS Baptist Medical Center
3435 NW 56th Street, Suite 101, OKC, OK 73112
405/951-8369 (Phone); 405/951-8376 (Fax)

INTEGRIS Southwest Medical Center
4221 S. Western Ave., Suite 1045, OKC, OK 73109
405/644-5128 (Phone); 405/644-5129 (Fax)

Patient name:_____ Date of birth:_____

Patient address:_____ Phone number(s):_____

Warfarin initiation date: _____ Current warfarin dose:_____

Indication(s) for warfarin therapy (please check all that apply):

- ❑ Arterial embolism/thrombosis
- ❑ Atrial fibrillation
- ❑ Cerebrovascular accident, ischemic
- ❑ Congestive heart failure, EF = _____
- ❑ Coronary artery disease
- ❑ Deep vein thrombosis of lower extremity
- ❑ Mechanical heart valve (type/position of valve): _____
- ❑ Peripheral vascular disease
- ❑ Pulmonary embolism
- ❑ Pulmonary hypertension, primary
- ❑ Pulmonary hypertension, secondary
- ❑ Thrombophillia: _____
- ❑ Transient ischemicattack
- ❑ Venous thrombosis of other specified vein:_____
- ❑ Other: _____

Duration of therapy

_____Weeks/Months/Years/Indefinitely

Target therapeutic range (please check below):

- ❑ **INR 2-3:** Low intensity (e.g., A.Fib., DVT, PE, VTE prophylaxis, CVA, TIA, Mechanical heart valve in aortic position)
- ❑ **INR 2.5-3.5:** High intensity (e.g., Mechanical heart valve in mitral position)
- ❑ Other_____ Reason: _____.

Laboratory (please report values and date of test):

Last reported CBC: WBC _____ Hgb _____ Hct _____ Plt _____ (date) _____

Last reported INR: _____ (date) _____ Baseline INR: _____ (date) _____

******We recommend that aspirin be discontinued due to increased risk of bleeding with warfarin. If aspirin is medically necessary we recommend 81 mg per day dosage. Please check the appropriate box below:******

- ❑ Discontinue aspirin therapy while this patient is taking warfarin.
- ❑ Please change current aspirin therapy to 81 mg/day.
- ❑ Please continue aspirin therapy at the following dose/day: _____

Authorization/Physician Order

I authorize the Integris Health Anticoagulation Clinic to monitor my patient's anticoagulation therapy and make adjustments as outlined in the Integris Anticoagulation Clinic protocols. I will be consulted prior to Vitamin K administration or planned interruption of warfarin therapy, to the extent prior notice was provided to the clinic. I have been provided with a copy of the Integris Anticoagulation Clinic protocols and guidelines (available at our website, www.integrisanticoag.com). I authorize the clinic to call in prescriptions for warfarin under my name, as needed for maintenance of my patient's anticoagulation therapy. I authorize the clinic to call in prescriptions for LMWHs, heparin, fondaparinux, or vitamin K per DVT protocol or per verbal authorization if situation warrants.

Signature of referring physician _____ Date: _____

Print name of referring physician: _____

Office location/address: _____

Office telephone: _____ Fax: _____ Pager number: _____

Thank you for your referral. Please fax form, recent History & Physical, and recent lab results to appropriate clinic.
CLINIC PROGRESS NOTES WILL BE AVAILABLE FOR REVIEW ON EPIC FOLLOWING EACH CLINIC VISIT.