

Anticoagulation Care Clinic

PHYSICIAN REFERRAL FORM

Please verify that the following criteria are met before referring your patient to the ACC:

1. ACC Referral Form must be completed by the referring physician.
2. ACC Referral Form must be faxed to 265-0660.
3. The referring physician must inform the patient that he/she will receive follow-up care in the ACC for his/her Coumadin[®] (warfarin) therapy.
4. The patient must meet the acceptance criteria as outlined in the ACC Policies and Procedures (available from the ACC).
5. The patient must have an initial ACC visit at the earliest open clinic date and be willing to make subsequent ACC appointments a minimum of every 4 – 6 weeks.
6. The patient must be managed by the referring physician until the patient is able to be seen in the ACC.

PLEASE PROVIDE THE FOLLOWING INFORMATION:

PATIENT NAME: _____ DOB: _____

Patient Phone Number: Home _____ Work _____

1. Indication for anticoagulation (Please mark indication):

- Atrial Fibrillation 427.31 Pulmonary Embolism 415.1 Prosthetic Heart Valve V43.3
 Deep Vein Thrombosis 453.8 Other _____

2. Current anticoagulation dose: _____

3. Goal INR (According to the American College of Chest Physician Guidelines): 2.0-3.0 2.5-3.5

I am requesting that the above patient's warfarin therapy be managed by the King's Daughters' Anticoagulation Care Clinic. The clinic will assume the responsibilities of ordering appropriate labs, adjusting doses, administering vitamin K when needed, and other necessary patient care interventions according to the established policies and procedures of the clinic as approved by the KDHHS Pharmacy and Therapeutics Committee.

Referring Physician: _____ Date: _____

Office Phone number: _____ Office Fax number: _____

Please fax completed forms to:
KDHHS Anticoagulation Care Clinic
FAX: 812-265-0660
Phone: 812-265-0883

NO STRAY MARKS BELOW THIS LINE



MOB 115 Rev 07/10



**ANTICOAGULATION CARE CLINIC
PHYSICIAN ORDER FORM**

Patient Identification: