

Patient Name: \_\_\_\_\_



**ANTICOAGULATION CENTER  
PATIENT REFERRAL FORM**

**Pharmacy to monitor INR and dose Coumadin in the Outpatient Anticoagulation Center per protocol. UR/RN to enter "Anticoag Center" consult in Invision prior to discharge.**

**Indication for anticoagulant therapy & requested therapeutic range (INR):**

- 1.6-2.5 or  2.0-3.0 Longterm (current) use of anticoagulants (V58.61) for Joint Replacement (Check:  Hip  Knee)
- 2.0-3.0 Acute myocardial infarction or  2.5-3.5 Prevention of recurrent myocardial infarction (410.92)
- 2.0-3.0 Atrial flutter (427.32)
- 2.0-3.0 Atrial fibrillation (427.31)
- 2.0-3.0 Cardiac Dysrhythmia, other (PSAT) (427.9)
- 2.0-3.0 LE Phlebitis (unspecified) 351.2,  LE Embolus/Thrombosis (453.8)
- 2.0-3.0 Pulmonary embolism (415.19)
- 2.0-3.0 Heart failure (428.9) \*Some patients may require modifications of INR goal
- 2.0-3.0 Bileaflet mechanical valve in aortic position (V43.3) Reference range (normal range INR) = 0.8-1.3
- 2.5-3.5 Mechanical valve replacement/ mechanical prosthetic valve (V43.3)
- 2.0-3.0 Cardiomyopathy (425.9)
- 2.0-3.0 Cerebrovascular disease (436)
- 2.0-3.0 Transient ischemic attack (435.9)
- 2.0-3.0 or  \_\_\_\_\_ Recurrent systemic embolism (Use same code as 1<sup>st</sup> occurrence)
- Other/Longterm (current) use of anticoagulants (please specify INR range & diagnosis):  
\_\_\_\_\_ (V58.61) Such as Lupus, Phospholipid Syndrome, etc.

**Requested duration of therapy:**  Chronic/ongoing or  To end \_\_\_\_/\_\_\_\_/\_\_\_\_ (total of \_\_\_\_  weeks/  months)

Inpatients will be seen within 24 hours of receipt of the referral. **Current warfarin dose:** \_\_\_\_\_

Expected hospital discharge date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Referring physician signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*This must be physician only\*

Patient Address: \_\_\_\_\_

Physician office phone: \_\_\_\_\_

\_\_\_\_\_

Physician office fax: \_\_\_\_\_

Patient phone number: \_\_\_\_\_

**\*Sign Order, Attach Face Sheet, H&P, & Insurance\***  
**& fax to 913-596-4636** Coventry Humana Gold need prior auth.

Physician office address: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex:  M  F

Emergency Contact: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Outpatients will receive initial assessment at the first visit (within 5 days of referral).

Inpatients will be seen within 5 days of discharge in the Anticoagulation Center.

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