☐ MR#:

☐ NAME:

☐ DOB:

☐ DATE:

UW HEALTH
ANTICOAGULATION SERVICE
REFERRAL FORM
INPATIENT & OUTPATIENT

☐ REFERRALS ARE PROCESSED BETWEEN 8:00 - 4:30PM, MON -- FRI

☐ CALL 263-8475 OR PAGE #7206 TO START REFERRAL PROCESS

☐ COMPLETION OF THIS FORM IS MANDATORY FOR ACCEPTANCE INTO THE SERVICE. INCOMPLETE FORMS WILL BE RETURNED

REFERRING PHYSICIAN: Please complete this section, sign, and then forward to nurse or medical assistant

PATIENT INDICATION FOR ANTICOAGULATION (check all that apply)

☐ DVT/PE PREVENTION reason: _____

☐ DVT/PE TREATMENT location: _____

☐ ATRIAL FIBRILLATION

☐ HX OF STROKE/TIA location/type: _____

☐ PROSTHETIC HEART VALVE location/type: _____

☐ COAGULOPATHY type: _____

☐ OTHER reason: _____

ANTICOAGULANT BEING PRESCRIBED

☐ WARFARIN (COUMADIN®) →

☐ DABIGATRAN (PRADAXA®)
☐ RIVAROXABAN (XARELTO®)
☐ APIXABAN (ELIQUIS®)
☐ EDOXABAN (SAVAYSA®)

TARGET INR
☐ 2.0 - 3.0 (e.g. afib, DVT/PE, mechanical AVR)
☐ 2.5 - 3.5 (e.g. mechanical MVR)
☐ 1.8 - 2.2 (e.g. VTE prevention s/p TKA/THA)
☐ OTHER: _____

☐ I WOULD LIKE HELP SELECTING THE MOST APPROPRIATE ANTICOAGULANT FOR THIS PATIENT

ANTICIPATED DURATION OF ANTICOAGULATION

☐ INDEFINITE
☐ 3 MONTHS
☐ 6 MONTHS
☐ OTHER: _____

NOTE: The referring or primary MD is responsible for anticoagulation management until the patient is seen in Anticoagulation Clinic (exception: orthopedic surgery or transplant patients).

☑ I hereby delegate anticoagulation management to UW Health Anticoagulation Clinic staff, in accordance with UW Health protocols

REFERRING PHYSICIAN SIGNATURE (Joint Commission requirement): _____ **pager #** _____
REFERRING PHYSICIAN PRINTED NAME: _____

NURSE/MEDICAL ASSISTANT: Please call 263-8475 to start the referral process. Then complete this section & fax to anticoagulation service at 263-8027.

SOCIAL HISTORY

☐ PATIENT IS INDEPENDENT
☐ CAREGIVER
(name, contact info): _____

WHERE IS PATIENT STAYING?
☐ Home ☐ Other:_____

ANTICOAGULATION HISTORY

IS PATIENT NEW TO ANTICOAGULATION?
☐ No
☐ Yes Date started: _____

PATIENT TYPE

☐ S/P UW ORTHOPEDIC SURGERY →

☐ UW TRANSPLANT PATIENT →
(new organ transplant OR new warfarin start)

Case manager: _____ pager # _____

Home health agency/Local lab: _____phone # _____

Anticipated date of discharge: _____

Date of first INR (for warfarin): _____

☐ OTHER →

PLEASE VERIFY THAT THIS PATIENT MEETS THE FOLLOWING ANTICOAGULATION CLINIC CRITERIA

☐ Must have UW Health PCP
☐ Must be able to have scheduled INR appts in Madison at Anticoag Clinic (UStation or West Clinic location)
☐ Cannot have Dean or Group Health primary insurance