### ANTICOAGULATION SERVICE

**Telephone:** 608-263-8475  
**Fax:** 608-263-8027  
**Pager:** 608-265-7000, pager ID 7206

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**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: __________________________

#### 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: __________________________

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**CASE MANAGER:** __________________________  pager # __________________________

**HOME HEALTH AGENCY/LAB:** __________________________  phone # __________________________

**ANTICIPATED DATE OF DISCHARGE:** __________________________

**DATE OF FIRST INR (FOR WARFARIN):** __________________________

**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

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**UW HEALTH**

**ANTICOAGULATION SERVICE**

**REFERRAL FORM**

**INPATIENT & OUTPATIENT**