

*Starred sections are required for patient to schedule an appointment Fax to: (425) 688-5710 Phone: (425) 688-5700

*Patient name: _____ *DOB: _____

*Reason for referral - check clinical indication(s) below ICD9: _____

*Physician name (please print) _____ NPI #: _____

Additional report to: _____

*Patient contact numbers: (home) _____ (work) _____ (cell) _____

Please assume evaluation, management, and education of anticoagulation therapy for this patient.

*Clinical Indication(s) (Please check all that apply)

| |
|-----------------------------------------------------------------------------------------------------------------|
| ARTERIAL THROMBOEMBOLISM |
| <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Acute Myocardial Infarction |
| <input type="checkbox"/> CVA |
| <input type="checkbox"/> Atrial Flutter |
| Biological (Tissue) Valve: <input type="checkbox"/> Aortic Position <input type="checkbox"/> Mitral Position |
| Mechanical Valve: <input type="checkbox"/> Aortic Position <input type="checkbox"/> Mitral Position |
| <input type="checkbox"/> Other: _____ |

| |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| VENOUS THROMBOEMBOLISM |
| <input type="checkbox"/> Deep-Vein Thrombosis (DVT) |
| Initial VTE Event associated with risk factors: <input type="checkbox"/> Factor V Leiden <input type="checkbox"/> Antiphospholipid Syndrome <input type="checkbox"/> Protein C/ S Deficiency <input type="checkbox"/> Other: _____ |
| DVT prophylaxis for: <input type="checkbox"/> THR <input type="checkbox"/> TKR <input type="checkbox"/> Hip Fracture <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Recurrent VTE |
| <input type="checkbox"/> Other: _____ |

Other pertinent medical history: _____

*Duration of treatment: Indefinite _____ Months _____ Weeks Other: _____

*Current warfarin dose: _____ mg Low molecular weight heparin _____ Dose: _____ mg
(Drug name)

***Therapeutic Range**

INR 2.0 to 3.0 using algorithm below (Atrial Fibrillation, CVA, TIA, PE, DVT-acute and prophylaxis, MI)

| | |
|----------------------|--------------------------------------------|
| INR less than 2.0 | Increase weekly dose 5-20% |
| INR 3 - 3.5 | Decrease weekly dose 5-15% |
| INR 3.6 - 4.0 | Hold 0-1 dose; decrease weekly dose 10-15% |
| INR greater than 4.0 | Hold 0-1 dose, decrease weekly dose 10-20% |

Other INR Range: _____

INR 2.5 to 3.5 using algorithm below (Mechanical Valve in Mitral Position or Aortic Position with risk factors, recurrent thrombosis)

| | |
|----------------------|-----------------------------------------------------|
| INR less than 2.0 | Add additional dose and increase weekly dose 10-20% |
| INR 2.0 - 2.4 | Increase weekly dose 5-15% |
| INR 3.6 - 4.6 | Decrease weekly dose 5-15% |
| INR 4.7 - 5.2 | Hold 0-1 dose, decrease weekly dose 10-20% |
| INR greater than 5.2 | Hold 0-2 doses, decrease weekly dose 10-20% |

| |
|----------------------------------------------------|
| Other dosing algorithm (must specify): |
|----------------------------------------------------|

Follow-up Algorithm:

| | | | | |
|------------------------------|-----------|---------|---------|---------|
| # Consecutive in-range INR's | 1 | 2 | 3 | 4 |
| Repeat INR in: | 5-10 days | 2 weeks | 3 weeks | 4 weeks |

Physician Signature

Date

Time

