UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Request for Services Form-Anticoagulation Management

Upper Chesapeake Medical Center-Pavilion II   Harford Memorial Hospital
510 Upper Chesapeake Drive, Suite 511   501 S. Union Ave.
Bel Air, MD 21014   Havre de Grace, MD 21078
Tel:443-643-3232   Tel:443-843-5570

Physician: Please complete A – E and FAX to 443-643-3299 (UCMC)   OR   443-843-5563 (HMH)   _____

DATE_____

A. Patient Name_____   Phone Number_____

SS#_____   M / F   DOB_____

If patient is currently on low-dose aspirin therapy (81-325 mg) do you want to continue this therapy?   _____yes _____no

B. **Indication for anticoagulation therapy:check all that apply   DATE COUMADIN (warfarin) STARTED:_____**

- o **Atrial Fibrillation**   **Appointment: ____ (in a few days)**
- o **Atrial Flutter**   **____ (in 1-2 weeks)**
- o **Heart Valve: Aortic _____   Mitral_____   Tricuspid_____**   **____ (next available)**
- o **Antiphospholipid Antibody Syndrome**
- o **Cardiomyopathy**
- o **Cerebrovascular Accident (CVA)**
- o **Congestive Heart Failure**
- o **Deep Vein Thrombosis**
- o **Mural Thrombus**
- o **Peripheral Vascular Disease**
- o **Pulmonary Embolism**
- o **Transient Ischemic Attack (TIA)**
- o **Other_____**
  (Diagnosis code required)

C. **Duration**   D. **INR Goal**

Life _____   **2.0-3.0 _____**

3 Months _____   **2.5-3.5 _____**

6 Months _____   **Other _____ (specify)**

Other _____ (specify)

E. **Referring Physician_____**

Primary Care Physician_____

Should an appointment not be available by the date requested, you will be informed to continue monitoring the patient until an appointment can be arranged.

This referral gives the Upper Chesapeake Health Anticoagulation Services (UCH ACS) authority to monitor and adjust the dosage of the above anticoagulant in this patient, based on UCH Medical Executive Committee-approved protocols, policies and procedures by pharmacists, under my oversight. The UCH AC Services pharmacist may also act as my agent in renewing prescriptions, or changing the dosage of prescriptions for the monitored anticoagulant; and may order additional pertinent labs or administer oral Vitamin K, if necessary.

_____   _____ _____
Physician's Signature   **Date**   **Time**

_____
Dictation ID #, Printed Name or Stamp

Office Telephone # _____   Office Fax #_____