GRAND LAKE™
HEALTH SYSTEM

Anticoagulation Clinic Patient Referral Form
Grand Lake Health System
200 St Clair Street, St Marys, OH 45885
Phone: 419.394.7386 Fax: 419.394.9560

Patient Information (please print): Date: _____

Patient Last Name: _____ First Name: _____ MI:____ DOB:_____
Patient Home Phone Number: (____) _____-_____ and/or Patient Cell Phone Number: (____) _____-_____
Patient Address: _____

Indication for Anticoagulation (check all that apply)
Note: In addition to 'Long-term (current) use of anticoagulants' and 'Encounter for therapeutic drug monitoring'

☐ **Atrial Fibrillation:** ☐ Chronic ☐ Paroxysmal ☐ Persistent ☐ Unspecified
☐ **Atrial Flutter**: ☐ Typical ☐ Atypical ☐ Unspecified
☐ **Treatment of Venous Thromboembolism (DVT / PE)**: ☐ DVT (vein _____); laterality _____)
☐ Pulmonary Embolism (PE)
☐ **Prevention of Venous Thromboembolism**: ☐ Post general surgery ☐ Post orthopedic surgery
☐ Post major gynecological / urological surgery
☐ **Valve Replacement:** ☐ Prosthetic (type: _____) ☐ Xenogenic (type: _____)
☐ Other: (type: _____)
☐ **Post Myocardial Infarction:** ☐ Warfarin only ☐ Warfarin + ASA
☐ **Coagulation Defects** ☐ Factor V Leiden ☐ Antithrombin III Deficiency ☐ Protein C Deficiency
☐ Protein S Deficiency ☐ Antiphospholipid Syndrome ☐ 20210A Mutation
☐ **Enoxaparin Bridge Therapy**: _____
☐ **Other**: _____

Medication
☐ warfarin (Coumadin) ☐ edoxaban (Savaysa)
☐ rivaroxaban (Xarelto) ☐ betrixaban (Bevyxxa)
☐ apixaban (Eliquis) ☐ dabigatran (Pradaxa)

Anticipated Duration of Anticoagulation
☐ Indefinite
☐ **Other:** _____

For Warfarin Referrals: Goals of Therapy
Target INR Range
☐ 2-3 (ACCP recommended for VTE (DVT/PE), AFib, AMI, etc.)
☐ 2.5-3.5 (specific types of mechanical valves or additional risk factors for thromboembolism: _____)

Anticoagulation History
Current medication and dosing regimen: _____
Most recent SrCr/INR (if applicable): _____/_____ Next scheduled SrCr/INR (if applicable): _____/_____
Any other comments: _____

Physician Authorization for Referral
This serves as referral to Grand Lake Health System Anticoagulation Clinic and *Collaborative Agreement* to monitor and adjust DOACs, Warfarin, Low Molecular Weight Heparin (LMWH), and Vitamin K per Protocol[1]
Physician Name: _____
Physician Phone Number: (____) _____-_____ Fax Number: (____) _____-_____:
Note: Patient to be followed by physician office until patient seen by anticoagulation clinic
➲ **Please provide most recent History & Physical and/or Consult Note, including a list of all active medications** ➲

➢➢ **PHYSICIAN SIGNATURE:** _____ **DATE:** _____ **(REQUIRED)** ➣➣
➢➢ **PATIENT SIGNATURE:** _____ **DATE:** _____ **(REQUIRED)** ➣➣
➢➢ **PHARMACIST SIGNATURE:** _____ **DATE:** _____ **(REQUIRED)** ➣➣

Patient will be managed and dosed according to the most recent American College of Chest Physicians (ACCP) Clinical Practice Guidelines. **If referring Physician not available in emergent situations, the Clinic Medical Director may be contacted to help assess and treat patient**. Fax completed form to 419.394.9560.

Excerpt from Department of Pharmacy Anticoagulation Clinic: Outpatient Anticoagulant Management Policy ACC-001[1]

1. The consulting provider is ultimately responsible for overseeing the care of the referred patients. Collaboration with the Anticoagulation Clinic Pharmacist is essential in facilitating the quality and continuity of care for the patients. The provider should notify the Anticoagulation Clinic if any of the below listed items occur:

    a. When the patient is hospitalized and discharged. The Anticoagulation Clinic will not be responsible for anticoagulation management during this time.
    b. When the patient's dosage is changed by a provider other than the Anticoagulation Clinic Pharmacist.
    c. When the patient is released from the referring provider's care or discharged from anticoagulation therapy.
2. The Anticoagulation Clinic Pharmacist is responsible to the consulting provider for the safe and efficient management of assigned patients. The clinic pharmacist will be responsible for the following:

    a. Ensuring all anticoagulant naive patients receive an initial education session with the designated written information and documentation within 2 weeks from enrollment.
    b. Reviewing need for ongoing anticoagulation therapy on all patient visits.
    c. Ordering appropriate labs, receiving and responding appropriately to lab results and communicating them to the provider and patient in a timely manner (within 24 hours).
    d. Adjusting medications and managing therapy according to the approved protocol.

3. The Anticoagulation Pharmacist must complete or be in the process of completing the following to be credentialed to work in the Anticoagulation Clinic:

    a. Complete a clinic approved anticoagulation certification course approved by the Joint Township District Memorial Hospital Director of Pharmacy.
    b. Receive approval to practice in the Anticoagulation Clinic by the Joint Township District Memorial Hospital Director of Pharmacy.
    c. Complete 2 hours of CE credit per year related to outpatient anticoagulation management.
    d. Anticoagulation Clinic Pharmacists must keep up to date annually with ongoing changes in anticoagulation management.

4. Random periodic evaluations of patient therapeutic management will be completed by the Anticoagulation Clinic Pharmacist and/or Medical Director and reported to the Joint Township District Memorial Pharmacy and Therapeutics Committee to ensure the protocol is adhered to.