

**Community Anticoagulation Therapy (CAT) Clinic Referral Form**  
600 Seventh Street SE  
Cedar Rapids, IA 52401  
319-558-4046

Patient name: \_\_\_\_\_ DOB \_\_\_\_\_  
 Patient home telephone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
 Referring physician: \_\_\_\_\_ Office #: \_\_\_\_\_  
 Office Fax #: \_\_\_\_\_ Nurse's name: \_\_\_\_\_  
 Primary physician: \_\_\_\_\_ Office #: \_\_\_\_\_

**Patient's INR to be checked by Referring physician until seen at CAT Clinic.**

<b><u>Primary Indication for Warfarin</u></b>	<input type="checkbox"/> 427.31 Atrial Fibrillation	<input type="checkbox"/> 424.1 Valve Disorder, Aortic
	<input type="checkbox"/> 451.83 Deep Vein Thrombosis, arm	<input type="checkbox"/> 424.0 Valve Disorder, Mitral
	<input type="checkbox"/> 451.19 Deep Vein Thrombosis, DVT	<input type="checkbox"/> V42.2 Valve, Bioprosthetic
	<input type="checkbox"/> 434.91 Stroke, CVA w infarct	<input type="checkbox"/> V43.3 Valve, Mechanical
	<input type="checkbox"/> 435.9 Transient Ischemic Attack, TIA	<input type="checkbox"/> Other: _____
<b><u>Desired INR Goal</u></b>	<input type="checkbox"/> <b>2.0 – 3.0</b> <input type="checkbox"/> <b>2.5 – 3.5</b> <input type="checkbox"/> Other _____	<b><u>Treatment Duration</u></b> <input type="checkbox"/> Lifetime user <input type="checkbox"/> To be determined <input type="checkbox"/> Date to stop: _____
<b>Medications including OTC and herbals</b> (may attach a list of medications)	<b>Coumadin/Warfarin Strength Dose</b> (Please circle one of above meds)	
_____	<input type="checkbox"/> 1 mg	_____
_____	<input type="checkbox"/> 2 mg	_____
_____	<input type="checkbox"/> 2.5 mg	_____
_____	<input type="checkbox"/> 3 mg	_____
_____	<input type="checkbox"/> 4 mg	_____
_____	<input type="checkbox"/> 5 mg	_____
_____	<input type="checkbox"/> 6 mg	_____
_____	<input type="checkbox"/> 7.5 mg	_____
_____	<input type="checkbox"/> 10 mg	_____

- Anticoagulation Medication     Coumadin     Warfarin     May substitute
- Prescription for warfarin/Coumadin per prescription guideline
- INRs and warfarin dosing per CAT Clinic guidelines
- CBC every 6 months

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
date

**Fax completed form, along with most recent history and physical, hospital course (if recently hospitalized), allergies, list of medications including coumadin log (includes dose and INR results) to:**  
**CAT Clinic: 319-558-4049**

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**Pt. Name** \_\_\_\_\_

**Referring Office** – complete as much as possible and fax with referral order ↓

<b>Bleeding Risk</b>				(Check all that apply) <input type="checkbox"/> Age $\geq$ 65 years <input type="checkbox"/> History of Stroke <input type="checkbox"/> History of GI Bleed <input type="checkbox"/> History of MI, Hct $<$ 30, Creat $>$ 1.5 or Diabetes Mellitus	<b>Date:</b> _____ _____ _____
<b>What risk factors are present?</b> Beyth RJ, Quinn LM, Landefeld CS. <b>Prospective evaluation of an index for predicting the risk of major bleeding in outpatients treated with warfarin.</b> American Journal of Medicine. 105(2):91-9, 1998. Institute for Clinic Systems Improvement (2005, April). Executive Summary, Anticoagulation Supplement, p. 23.					
<b>Classify your patient</b>				<input type="checkbox"/> Low Risk (0 Risk Factors) <input type="checkbox"/> Intermediate Risk (1-2 Risk Factors) <input type="checkbox"/> High Risk ( $\geq$ 3 Risk Factors)	
<b>Sum of Risk Factors</b>					
Risk classification	Low 0	Intermediate 1-2	High 3-4		
Risk of major bleeding					
within 3 months	2%	5%	23%		
within 12 months	3%	12%	48%		

Source: [http://www.ecu.edu/anticoagulation/AC%20Clinic%20Referral-Chart%20Form\\_Final.pdf](http://www.ecu.edu/anticoagulation/AC%20Clinic%20Referral-Chart%20Form_Final.pdf)