

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.

Primary Indication for Warfarin	<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"/> 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: _____
Desired INR Goal	<input type="checkbox"/> 2.0 – 3.0 <input type="checkbox"/> 2.5 – 3.5 <input type="checkbox"/> Other _____	Treatment Duration
Medications including OTC and herbals (must attach a list of medications)		<input type="checkbox"/> Coumadin/Warfarin Strength _____ Dose _____ (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 indication Coumadin Warfarin May substitute
- Prescribed 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

This is a sample page from the CRHA Toolkit. For more information or to obtain hi-resolution printable copies of these documents, please visit www.crhealthcarealliance.org

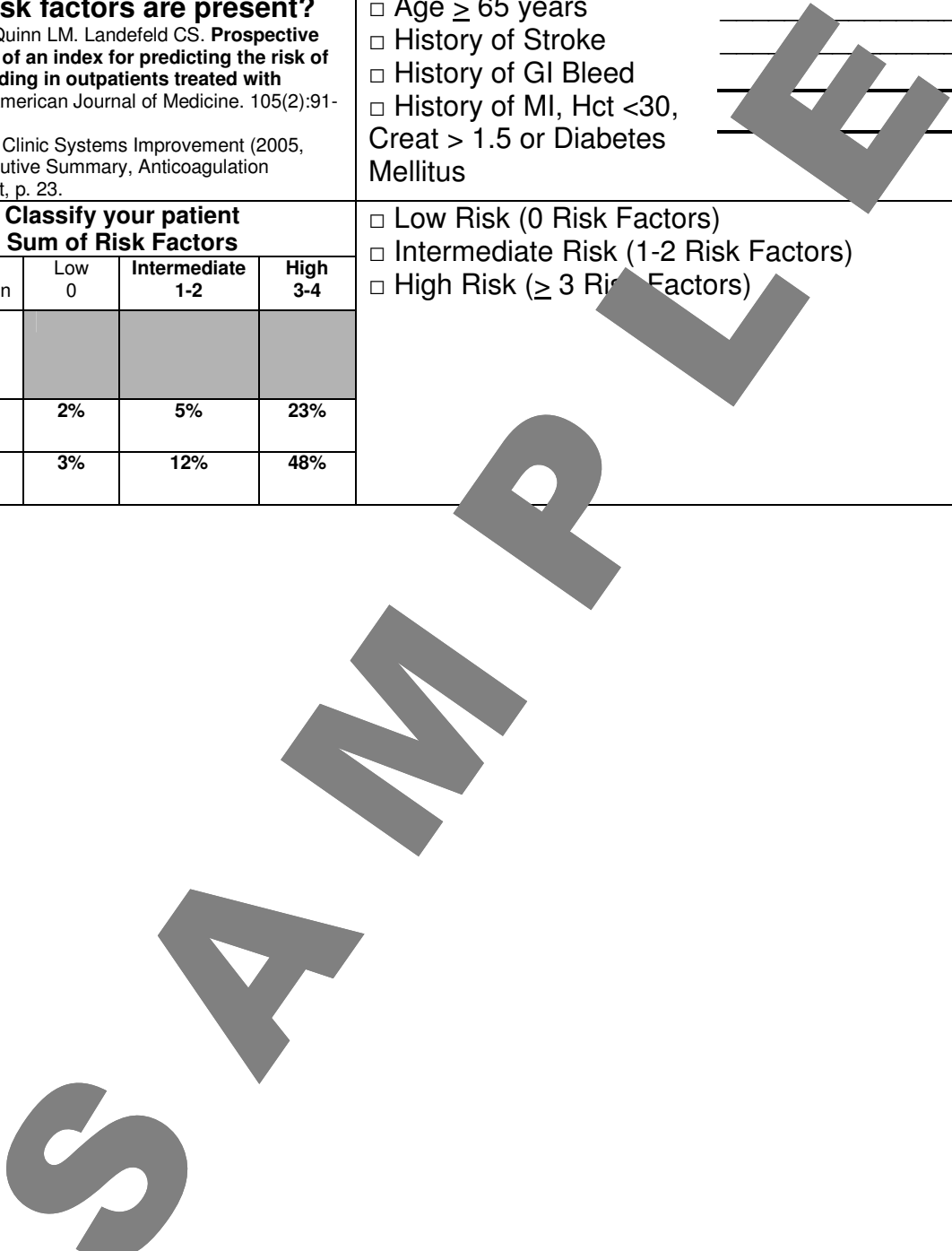
Community Anticoagulation Therapy (CAT) Clinic Referral Form

Pt. Name _____

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

Bleeding Risk				(Check all that apply) <input type="checkbox"/> Age ≥ 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	Date: _____ _____ _____
What risk factors are present? Beyth RJ, Quinn LM, Landefeld CS. Prospective evaluation of an index for predicting the risk of major bleeding in outpatients treated with warfarin. American Journal of Medicine. 105(2):91-9, 1998. Institute for Clinic Systems Improvement (2005, April). Executive Summary, Anticoagulation Supplement, p. 23.					
Classify your patient				<input type="checkbox"/> Low Risk (0 Risk Factors) <input type="checkbox"/> Intermediate Risk (1-2 Risk Factors) <input type="checkbox"/> High Risk (≥ 3 Risk Factors)	
Sum of Risk Factors					
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%		

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Source: http://www.ecu.edu/anticoagulation/AC%20Clinic%20Referral-Chart%20Form_Final.pdf