Appendix A

NORTHWEST ANTICOAGULATION CLINIC

Physician Referral/Collaborative Care Form

Phone: (206)668-1282/ FAX: (206) 668-3004

Patient Name: _____ DOB _____ **Sex**
Patient's Phone: _____ Cell: _____
Other contact number/person: _____
Attach face sheet or provide Address: _____
_____

Indication for Anticoagulation: _____
ICD9 or ICD10 code(s) _____
Target INR Range: _____
Suggested date of first appointment? _____
(Clinic closed weekends and holidays)
Anticipated Duration of Anticoagulation: _____

Current Warfarin Strength and dosage regimen: _____
Date of last INR _____ **and INR value** _____

Complicating Factors/Other Diagnosis: Attach H&P, medication list, problem list and warfarin flow sheet if available

I, _____, the referring physician
(Please print)
will be the collaborative physician of record, granting prescriptive authority to the clinical staff according to the protocol approved by the Washington State Board of Pharmacy.

Phone: _____

FAX Number: _____

Physician Signature: _____ Date: _____