FIRELANDSHEALTH
Firelands Regional Medical Center

Center for Coordinated Care
Patient Referral Form

1221 Hayes Avenue Suite F Sandusky, Ohio
Phone: 419-557-6550 Fax: 419-621-1047

Please complete and fax this form to the FCCC Antithrombosis Clinic @ 419-621-1047

Patient Name_____ **DOB** _____ **Phone #** _____

☐ **WARFARIN MANAGEMENT**

Indication: _____

Date of diagnosis/last event_____ Date of warfarin initiation: _____

Current warfarin daily dose and schedule: _____

Goal INR range: _____ Planned duration of anticoagulation: _____

☐ **LOW-MOLECULAR-WEIGHT HEPARIN (LMWH) MANAGEMENT**

Indication: _____

Current LMWH daily dose and schedule: _____

Start date: _____ Planned stop date (or duration): _____

☐ **RIVAROXABAN, APIXABAN, OR DABIGATRAN MANAGEMENT**

Indication: _____

Current daily dose and schedule: _____

Start date: _____ Planned stop date (or duration): _____

This serves as referral to Firelands Anticoagulation Clinic and *Consult Agreement* for pharmacists to monitor and adjust anticoagulation medications per protocol for a period of up to 2 years.

Provider Signature: _____ Date: _____

Provider Print Name: _____

Provider office phone #: _____ Fax #: _____
INR results and progress notes will be faxed to referring provider after each visit.

TO BE COMPLETED AT FIRELANDS ANTICOAGULATION CLINIC:

Patient Signature: _____ Date: _____

Pharmacist Signature: _____ Date: _____

Patient will be managed according to the most recent American College of Chest Physicians Clinical Practice Guidelines. If referring physician is not available in emergent situations, the clinic Medical Director may be contacted to assess and treat patients.

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