

I. Appendix A

NORTHWEST ANTICOAGULATION CLINIC

Physician Referral Form

Phone: (206)368-1282/ FAX: (206) 368-3004

II. Physician to Complete:

Patient Name: _____

Anticipated Date of First Clinic Visit: _____

Indication for Anticoagulation: _____

_____ ICD9 code(s) _____

Target INR Range: _____

Anticipated Duration of Anticoagulation: _____

Warfarin Pill Strength: _____ Brand or Generic

Current Warfarin Regimen: _____

Most Recent INR: _____ Date done _____

Complicating Factors/Other Diagnosis: _____

Referring MD: _____ Phone: _____

Follow-Up Physician: _____ Phone: _____

Office FAX Number to send patient Anticoagulation Clinic Progress Notes for your

Record keeping: _____

**PLEASE ATTACH THE MOST RECENT HISTORY AND PHYSICAL,
MEDICATION LIST, LABORATORY DATA, AND ANTICOAGULATION FLOW**

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Patient's Phone: _____ Cell: _____ Wk: _____

Address: _____

Date of Birth: _____

Physician Signature: _____ Date: _____

Print Name: _____