UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Request for Services Form-Anticoagulation Management

Upper Chesapeake Medical Center-Pavilion II 510 Upper Chesapeake Drive, Suite 511 Bel Air, MD 21014 Tel:443-643-3232	Harford Memorial Hospital 501 S. Union Ave. Havre de Grace, MD 21078 Tel:443-843-5570

Physician: Please complete A – E and FAX to 443-643-3299 (UCMC) OR 443-843-5563 (HMH)

DATE________________________________

A. Patient Name____ **Phone Number**________________________

SS#_________________________ **M / F** **DOB**_____________________________

If patient is currently on low-dose aspirin therapy (81-325 mg) do you want to continue this therapy? _______yes _____no

B. Indication for anticoagulation therapy: check all that apply **DATE COUMADIN STARTED:**_________

PLEASE INCLUDE ICD10 CODE FOR ALL DIAGNOSES CHECKED.

- o **Atrial Fibrillation** ____________________
- o **Atrial Flutter** ____________________
- o **Antiphospholipid Antibody Syndrome** ____________________
- o **Cardiomyopathy** ____________________
- o **Cerebrovascular Accident (CVA)** ____________________
- o **Congestive Heart Failure** ____________________
- o **Deep Vein Thrombosis** ____________________
- o **Mural Thrombus** ____________________
- o **Peripheral Vascular Disease** ____________________
- o **Pulmonary Embolism** ____________________
- o **Transient Ischemic Attack (TIA)** ____________________
- o **Heart Valve: Aortic _____ Mitral_______ Tricuspid______** ____________________
- o **Other**________________ **(Diagnosis code required)** ____________________

Appointment:

_______ **(in a few days)**

_______ **(in 1-2 weeks)**

_______**(next available)**

C. Duration

Life _____

3 Months _______

6 Months _______

Other ______________ **(specify)**

D. INR Goal

2.0-3.0 _______

2.5-3.5 _______

Other ________ **(specify)**

E. Referring Physician____

Primary Care Physician____

Should an appointment not be available by the date requested, you will be informed to continue monitoring the patient until an appointment can be arranged.

This referral gives the Upper Chesapeake Health Anticoagulation Services (UCH ACS) authority to monitor and adjust the dosage of the above anticoagulant in this patient, based on UCH Medical Executive Committee-approved protocols, policies and procedures by pharmacists, under my oversight. The UCH AC Services pharmacist may also act as my agent in renewing prescriptions, or changing the dosage of prescriptions for the monitored anticoagulant; and may order additional pertinent labs or administer oral Vitamin K, if necessary.

____ ____________ ___________

Physician's Signature **Date** **Time**

____

Dictation ID #, Printed Name or Stamp

Office Telephone # _________________________________ **Office Fax #**_____________________________