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

Physician: Please complete A – E and FAX to 443-643-3299

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 (warfarin) STARTED:**_____

- **Atrial Fibrillation**
- **Atrial Flutter**
- **Heart Valve: Aortic _____ Mitral_____ Tricuspid_____**
- **Antiphospholipid Antibody Syndrome**
- **Cardiomyopathy**
- **Cerebrovascular Accident (CVA)**
- **Congestive Heart Failure**
- **Deep Vein Thrombosis**
- **Mural Thrombus**
- **Peripheral Vascular Disease**
- **Pulmonary Embolism**
- **Transient Ischemic Attack (TIA)**
- **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 #**_____