



calgary health region

leaders in health - a partner in care

Site: _____

MRN: _____ Site: _____ DOB: yyyy/mon/dd

Last Name: _____ First and Additional Names: _____

PHN: _____ Gender: _____ Age in Years: _____

Admitting Physician: _____ Encounter #: _____

Address: Street, City, Province, Postal Code

Telephone Number: _____

Date of Admission: yyyy/mon/dd Family Physician: _____

Anticoagulation Management Services Referral Form

24 hours notice required prior to discharge - phone clinic with referral

Date (yyyy/mon/dd)	Time	Location <input type="checkbox"/> ED <input type="checkbox"/> Unit _____ <input type="checkbox"/> Community
Referring Physician		Phone: _____ Family Physician (if different than referring)
Indication for Anticoagulation (✓ all that apply)		
<input type="checkbox"/> DVT/Vessel: _____ <input type="checkbox"/> PE <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Stroke <input type="checkbox"/> TIA <input type="checkbox"/> MI Date: (yyyy/mon/dd) _____ <input type="checkbox"/> LV Dysfunction <input type="checkbox"/> Thrombophilia <input type="checkbox"/> Native valvular disease <input type="checkbox"/> Valve replacement <input type="checkbox"/> Mitral <input type="checkbox"/> Aortic <input type="checkbox"/> Bioprosthetic <input type="checkbox"/> Mechanical Type: _____ <input type="checkbox"/> LMWH Bridging for invasive procedure: _____ Procedure Date: (yyyy/mon/dd) _____ Weight _____ kg Serum Creatinine _____ Date: (yyyy/mon/dd) _____		

Physician Orders

LMWH Prescription <input type="checkbox"/> Tinzaparin 175 units/kg SC daily <input type="checkbox"/> Dalteparin 200 units/kg SC daily <input type="checkbox"/> Enoxaparin 1.5 mg/kg (DVT only) SC daily For acute coronary syndromes <input type="checkbox"/> Dalteparin 100 units/kg SC q12h <input type="checkbox"/> Enoxaparin 1 mg/kg SC q12h <input type="checkbox"/> Other LMWH (specify drug, dose, frequency, duration): _____ All LMWH will continue until INR in target range x 2 consecutive days	<input type="checkbox"/> Vitamin K 1 mg/mL suspension 10 mL Take as directed by AMS for supratherapeutic INR. <input type="checkbox"/> Compression Stockings Duration of Therapy <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Indefinite <input type="checkbox"/> Other: _____	Physician Signature <ul style="list-style-type: none"> This signature authorizes clinic staff to manage patient according to approved Regional Anticoagulation protocols Physician signature required to process referral
<input type="checkbox"/> Warfarin	INR Target Range: <input type="checkbox"/> 2.0 - 3.0 <input type="checkbox"/> 2.5 - 3.5 <input type="checkbox"/> Other: _____ <input type="checkbox"/> Follow-up with referring physician needed in: _____ months <input type="checkbox"/> Arrange thrombophilia testing 4-6 weeks following treatment	

For more information please go to www.calgaryhealthregion.ca/cdm/algorithms/disease.html

Fax completed referral form, ED chart, history, diagnostic procedure results to:

FMC Phone: 944-2784 Fax: 944-8174

PLC Phone: 943-5584 Fax: 250-1894

RGH Phone: 943-8710 Fax: 943-3619

AMS Clinics are open Monday to Friday* *excluding holidays