1400 West Main Street, Bldg. 1, Suite D
Bellevue, Ohio 44811
Phone: 419.484.5970
Fax: 419.484.5917

Medication Management Clinic
Patient Referral Form

PATIENT INFORMATION

Date: _____
Patient Last Name: _____ **First Name:** _____ **MI:** _____ **DOB:** _____
Patient Home Phone Number: (_____) _____-_____ *and/or* **Patient Cell Phone Number:** (_____) _____-_____
Patient Address: Street Address _____
City: _____ State: _____ Zip: _____

INSURANCE INFORMATION: *(Please verify insurance card(s) / ID Each visit)*

Is this patient covered by insurance? ☐ Yes ☐ No
Please indicate Primary Insurance: _____
Subscriber's Name: _____
SS#: _____ DOB: _____ Group #: _____ Policy #: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____
Name of Secondary Insurance: _____
Subscriber's Name: _____
SS#: _____ DOB: _____ Group #: _____ Policy #: _____
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

INDICATION/GOALS (Check all that apply)

☐ **Atrial Fibrillation/Flutter** (☐ Chronic ☐ New onset ☐ Paroxysmal)
☐ **Treatment of Venous Thromboembolism (DVT/PE)** → ☐ DVT, 1st (location_____) ☐ DVT, recurrent
☐ Pulmonary embolism (PE) 1st ☐ PE, recurrent
☐ **Prevention of Venous Thromboembolism** → ☐ Post general surgery ☐ post orthopedic surgery
☐ Post major gynecological/urological surgery
☐ **Valve Replacement** → ☐ Mitral (type _____) → ☐ Aortic (type _____)
☐ Mechanical → ☐ Bioprosthetic
☐ **Post Mycocardial Infarction** → ☐ Warfarin only ☐ Warfarin + ASA
☐ **Enoxaparin Bridge Therapy:** _____
☐ **Comprehensive Medication Review:** _____ ☐ **Other:** _____

GOALS OF THERAPY

Target INR Range:
☐ 2-3 (ACCP recommended for VTE (DVT, PE) A. Fib, AMI, etc.)
☐ 2.5-3.5 (specific types of mechanical valves or additional risk factors for thromboembolism: _____)

Recent Warfarin History
It will be very helpful to have results of most recent INR's and dosage:
Current dose and schedule: _____
INR/Date: ____/____ ____/____ ____/____ ____/____ ____/____

Any other comments: _____

Anticipated Duration of Anticoagulation
☐ 3 months
☐ 6 months
☐ Indefinite
☐ **Other:** _____

Coagulation Defects
☐ Antithrombin deficiency
☐ Protein C deficiency
☐ Protein S deficiency
☐ Factor V Leiden
☐ Antiphospholipid syndrome
☐ 20210A mutation or Other

PHYSICIAN AUTHORIZATION FOR REFERRAL

This serves as referral to **The Bellevue Hospital Medication Management Clinic** and *Collaborative Agreement* to monitor and adjust Warfarin, Low Molecular Weight Heparin, Vitamin K per Protocol.
Physician Name: _____ (Please print) **Date:** _____
Physician Phone #: (_____) _____ **Fax: #:** (_____) _____
Note: Patient to be followed by physician office until patient seen by the Medication Management Clinic.
*****Please include most recent History & Physical and/or Consult Note with this referral*****

▸▸ **PHYSICIAN SIGNATURE:** _____

Patient will be managed and dosed according to the most recent American College of Chest Physicians Clinical Practice Guidelines. If Referring Physician not available in emergent situations, the Clinic Medical Director may be contacted to help assess and treat patient. Fax completed form to (419) 484-5917.