Date: ____________________

Patient Name: ____

Anticipated Date of First Anticoagulation Visit: ____

Note: The Anticoagulation Service is closed weekends and major holidays

Diagnosis/Indication for Anticoagulation: ____

Service: ☐ Warfarin Management ☐ DOAC selection and management ☐ DOAC education

Target INR Range (warfarin): ________________

Anticipated Duration of Anticoagulation: _____________________

Complicating Factors / Other Diagnosis: ____

____

Referring MD: ____

Follow-up Physician: ____________________________________

Office Fax Number to send patient information: ______________________________________

Ordered Frequency of PT/INR Test and Clinic Visit: Following each clinic visit, dosage change and/or evaluation by pharmacist. Or, specify alternate lab test schedule: _____________

IF THIS IS AN OUT PATIENT OFFICE REFERRAL, PLEASE ATTACH MOST RECENT HISTORY AND PHYSICAL AND OFFICE ANTICOAGULATION FLOW SHEET

PLEASE COMPLETE THE FOLLOWING INFORMATION

Patient’s Home Telephone Number: ______________________________

Address: ____

Date of Birth: ____

_____________________________________ _____________________

Physician Signature* **Date and Time**

*Signature indicates provider’s order for evaluation and management of anticoagulation therapy by Evergreen Hospital Medical Center Anticoagulation Service, assignment of benefits for anticoagulation management to Evergreen Healthcare and authorization for the use of Washington State Board of Pharmacy approved collaborative management agreement.

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Pharmacist Provider Service; Anticoagulation Management
Phone: (425) 899-2783 Fax: (425) 899-2784

EvergreenHealth Kirkland, WA 98034

PHARMACIST PROVIDER SERVICE; ANTICOAGULATION MANAGEMENT
REFERRAL AND PATIENT-SPECIFIC TREATMENT PLAN

FORM ID RX 268

Approved 8/21

APPLY PATIENT LABEL HERE

Original – Medical Record

MR