**ANTICOAGULATION CLINIC REFERRAL FORM**

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| **NOTE: NO APPOINTMENT will be made in the anticoagulation clinic UNLESS THIS FORM IS COMPLETED IN *FULL.*** | **Contact the Anticoagulation Clinic** |
| QEIIExt: 01707 247588 | ListerExt: 01438 285335 |

**anticoagulationenh-tr@nhs.net**

**Date of Referral:** <Today's date>

|  |  |
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| **Referring Consultant:** <Sender Name>**Organisation:** <Sender Details>**Referring Consultant Tel No.** <Sender Details>**Prescribing Doctor:**      **Bleep:**      **Date of Discharge:**      **Date of A/C Clinic appt:**      **Phone no of patient:** <Patient Contact Details> | **Hospital No:**       **DOB:** <Date of Birth>**Surname:** <Patient Name>**First Name:** <Patient Name>**Address:** <Patient Address>**NHS No:** <NHS number>**GP:** <GP Name> |

**Reason for Referral:**

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|      <Event Details> |

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| **Indication for Anticoagulation – Please tick that which applies** |
| **CONDITION** | **Target INR** | **DURATION** |  |
| Atrial fibrillation / Cardioversion | 3.0 (2.5-3.5) | 6 weeks pre and 4 weeks post cardioversion | [ ]  |
| Atrial fibrillation / Flutter | 2.5 (2.0-3.0) | Long term | [ ]  |
| PE | 2.5 (2.0-3.0) | 6 months | [ ]  |
| Proximal DVT (includes popliteal) | 2.5 (2.0-3.0) | 6 months | [ ]  |
| Calf DVT | 2.5 (2.0-3.0) | 3 months | [ ]  |
| Recurrent DVT | 2.5 (2.0-3.0) | Long Term | [ ]  |
| Recurrent PE | 2.5 (2.0-3.0) | Long term | [ ]  |
| Recurrent VTE despite therapeutic INR | 3.5 (3.0-4.0) | Long term | [ ]  |
| Cardiomyopathy/Mural Thrombus or akinetic segment | 2.5 (2.0-3.0) | Long term | [ ]  |
| Pulmonary Hypertension | 2.5 (2.0-3.0) | Long Term | [ ]  |
| Mechanical AVR (bileaflet or tilting disc) | 2.5 (2.0-3.0) | Long term | [ ]  |
| Mechanical MVR (bileaflet or tilting disc) | 3.0 (2.5-3.5) | Long term | [ ]  |
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| **IF PRESCRIBING A NOAC IE: DABIGATRAN/RIVAROXABAN/APIXABAN** **PLEASE RING THE ANTICOAGULANT CLINIC TO REFER** |  |  |  |

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| **Clinical Information:** |
| **IF REFERRING FOR AF, PLEASE STATE CHADS2/CHADSVASC SCORE:** |
|       |
| **IS THIS PATIENT ON:** **[ ]  ASPIRIN** **[ ]  CLOPIDOGREL** **[ ]  OTHER ANTIPLATLET DRUG** **(Please Specify)?** |
|       |
| **IS THIS TO CONTINUE DURING ANTICOAGUALTION:** **[ ]  YES** **[ ]  NO****ALL CURRENT MEDICATIONS:** |
| Acutes | <Medication> |
| Repeats | <Repeat templates> |

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| **Past Medical History:** |
|  |  | ***If No please specify below*** |
| **History of Peptic Ulceration?** | [ ]  Yes | [ ]  No |
| **History of Liver Disease?** | [ ]  Yes | [ ]  No |
| **History of Renal Impairment?** | [ ]  Yes | [ ]  No |
| **Uncontrolled hypertension?** | [ ]  Yes | [ ]  No |
| **Congestive cardiac failure?** | [ ]  Yes | [ ]  No |
| **Alcohol excess?** | [ ]  Yes | [ ]  No |
| **Any other relevant medical / family history?** |  |  |
|      <Problems><Summary> |

**Allergies:**

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| <Allergies & Sensitivities> |

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| **It is the referring teams responsibility to refer ALL PATIENTS with a unprovoked Pulmonary Embolism to a chest Physician** |
| **Patients with METASTATIC MALIGNACY may require an INDIVIDUAL ANTICOAGULANT PLAN.** |

**East & North Hertford**