ASHFORD AND ST PETERS NHS TRUST – ANTICOAGULANT CLINIC REFERRAL FORM
PLEASE COMPLETE FORM ON BOTH SIDES

Please note that patients will not be accepted for warfarin treatment and monitoring by the clinical haematology service unless an appropriately completed referral form is available at the first visit.

Patient Name:	Referring Consultant/GP:
Date of Birth:	Ward Name/A&E/MAU:
Hospital Number:	Discharge Date:
Telephone Number:	Reason for Admission:
Address:	New Patient / re referral:
GP Name/Practice	Clinic date given to patient:

Please Tick All RELEVANT	INDICATION (please tick all appropriate boxes)	TARGET INR (circle or complete)	DURATION (circle)
( )	**ATRIAL FIBRILLATION**	**2.0 – 3.0**	**LT**
	( ) Associated Valvular Heart Disease		
	( ) Associated Ischaemic Heart Disease		
	( ) Associated Hypertension		
	( ) History of Arterial Embolism		
	( ) History of Stroke		
	( ) History of TIA's		
	( ) Age over 75 years		
	( ) **PRE CARDIOVERSION**	**2.5 – 3.5**	**as advised by cardiologist**
	Date if known.....		
( )	**Venous Thromboembolism**	**2.0 – 3.0**	**6 months**
	( ) DVT – First Episode		
	Site and Extent.....		
	( ) Positive Doppler/Venogram		
	( ) Cerebral vein thrombosis		
	( ) Post op calf vein thrombosis	**2.0 – 3.0**	**6 weeks**
	( ) PE first Episode	**2.0 – 3.0**	**6 months**
	( ) Positive VQ Scan/CT Scan		
	( ) Recurrent P/E/ DVT – **OFF WARFARIN**	**2.0 – 3.0**	**6 months / LT**
	( ) Recurrent P/E/ DVT – **ON WARFARIN**	**3.0 – 4.0**	**LT**
	Implicated risk factors		
	( ) Post operative		
	( ) Pregnancy		
	( ) OC Pill		
	( ) Malignancy		
	( ) Known Thrombophilia - please specify		
	( ) Other - please specify.....		
( )	**Cardiac Disease**		
	( ) Myocardial Infarction	**2.0 – 3.0**	**Specify length of treatment**
	( ) CABG		
	( ) Mitral Stenosis		
	( ) Mechanical Valve Replacement **Aortic / Mitral**	**3.0 – 4.0**	**LT**
	( ) Other Valve Replacement	**2.0 – 3.0**	
( )	**Arterial Disease**		
	( ) TIA	**2.0 – 3.0**	
	( ) Ischaemic CVA	**2.0 – 3.0**	
	( ) Lupus Anticoagulant		
( )	**Prophylaxis**		
	( ) Post Operative		
	( ) Postnatal		
	( ) Malignant Disease		
	( ) Cardiac Failure		
	( ) Immobility		
	( ) Other		
	Please specify.....		
( )	**Other**		
	Please specify.....		
	.....		
	.....		

Relevant Past Medical History **No ( )** **Yes ( ) please specify**

Family History of Venous Thromboembolism **No ( )** **Yes ( ) please specify**

Current Medication, Vitamin and Herbal Supplements

Aspirin/Other Antiplatelet drugs? This will be discontinued at Anticoagulant Clinic unless specifically requested by Consultant.

Aspirin / Clopidogrel to continue Yes / No (delete as applicable)

Known Potential Contraindications to Anticoagulation

• History of peptic ulcer	( )	Yes	( )	No
• History of significant bleeding disorder	( )	Yes	( )	No
• Known allergy to warfarin	( )	Yes	( )	No
• Uncontrolled hypertension	( )	Yes	( )	No
• Recent haemorrhage stroke	( )	Yes	( )	No
• Retinal haemorrhages	( )	Yes	( )	No
• Other please specify.....	( )	Yes	( )	No

Patients weight for dose calculation:

Date Enoxaparin started:

Dose Enoxaparin **.....ml subcutaneously od**

Any other relevant information: Please include recent significant illness/ surgery and changes to medication

Daily/Weekly units of alcohol consumed

Form completed by:

Signature: **Please print name:** **Please give bleep no or extension:**

Warfarin Dosing History: *you must give at least the last three doses and INRs*

Date Warfarin Started:

DATE	INR	Warfarin DOSE GIVEN