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.

<table>
<thead>
<tr>
<th>Please Tick</th>
<th>INDICATION</th>
<th>TARGET INR</th>
<th>DURATION</th>
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</thead>
<tbody>
<tr>
<td>All RELEVANT</td>
<td>ATRIAL FIBRILLATION</td>
<td>2.0 – 3.0</td>
<td>LT</td>
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<tr>
<td>( )</td>
<td>Associated Valvular Heart Disease</td>
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<td>( )</td>
<td>Associated Ischaemic Heart Disease</td>
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<td>Associated Hypertension</td>
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<td>( )</td>
<td>History of Arterial Embolism</td>
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<td>History of Stroke</td>
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<td>History of TIA's</td>
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<td>Age over 75 years</td>
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<td>( )</td>
<td>PRE CARDIOVERSION Date if known</td>
<td>2.5 – 3.5</td>
<td>as advised by cardiologist</td>
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</table>

( ) Venous Thromboembolism

( ) 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

( ) 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
  Yes ( ) No
- Retinal haemorrhages
  Yes ( ) No
- Other please specify

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:

<table>
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<tr>
<th>DATE</th>
<th>INR</th>
<th>Warfarin DOSE GIVEN</th>
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