LIFEBRIDGE HEALTH
CARE BRAVELY

Anticoagulation Clinic Referral Form

200 Memorial Ave.
Westminster, MD 21157
Phone: 410-871-6157 | Fax: 410-871-7199

Place Patient Label Here

94001

Patient Information

Name:_____ Birthdate:_____ Patient Phone # :_____

Address:_____ City:_____ State:_____ Zipcode:_____

Primary Care Physician:_____ Phone Number:_____

Insurance Information

Primary Plan Name:_____

Primary Policy #: _____ Primary Group #:_____

Primary Phone Number:_____ Primary Pre Cert #:_____

Primary Policy Holder Place of Employment:_____

Secondary Plan Name:_____

Secondary Policy #:_____ Secondary Group #:_____

Secondary Phone #:_____ Secondary Pre Cert #:_____

Secondary Policy Holder Place of Employment:_____

ICD-10 for anticoagulation: _____

Diagnosis/Pertinent History/Reason for anticoagulation therapy:

_____

_____

_____

Medication ☐ Warfarin ☐ Apixaban ☐ Rivaroxaban ☐ Dabigatran ☐ Edoxaban

1. Anticipated Duration: ☐ Life ☐ 3 Months ☐ 6 Months ☐ Other: _____

2. Warfarin Only: ☐ INR=2.0-3.0 ☐ INR=2.5-3.5 ☐ Other: _____

May patient take low dose aspirin (*ie. 81-165 mg*) if indicated? ☐ Yes ☐ No

Reporting Mechanisms:
Do you want clinic notes sent to you? ☐ Yes ☐ No

☐ Courier (Specify Office_____) ☐ Via mail (Specify Office_____)

I give my authorization for Carroll Hospital Anticoagulation Clinic to monitor and adjust anticoagulant dose of this patient based on established protocols, policies, and procedures.

_____ _____ _____

Physician Signature | Printed Name / Phone Number | Date & Time