Anti-coagulation referral form

Highlighted sections are compulsory. Any incomplete referrals will be returned.

Patient details:

Surname……
First name……..
D.O.B:……..
Gender:……
Address……...
……..
Postcode……
Tele No……
Mobile……..
Email……

NHS number…..……
Is an Interpreter required: Yes / No
Housebound: Yes / No
Reason : ……

Referrer:

Name……..
Designation……
Address…….....
……..
Postcode……
Tele No……
Email……

GP:

Name (If different)……..
Address……
……
Postcode……
Telephone……

Diagnosis:

Antiphospholipid Syndrome	Yes / No
Arterial Thromboembolism	Yes / No
Atrial Fibrillation	Yes / No
Cardiomyopathy	Yes / No
Mechanical Prosthetic	Yes / No
Heart Valve	Yes / No
Recurrence of DVT/PE	Yes / No
How many? 1 2 3 or More (please circle)	
Bioprosthetic Valve	Yes / No
Pacemaker	Yes / No

Other; (please state)……..
Date of diagnosis……

Date commenced on Warfarin:…….. Loading dose……
Current Warfarin dose…….. Range……
Has patient been counselled Yes / No Next INR due date……

Last four INRS:

Date……	Date……..	Date……	Date……..
INR……..	INR……	INR……	INR……
Dosage……	Dosage……	Dosage……	Dosage……

Infection control status:

Is the patient known to have any infections? Yes / No

If yes – what are the details?.....

A recent history of vomiting and/or diarrhoea? Yes / No

If yes date of onset and last episode?.....

Please list medications history:

Drug	Yes / No	Drug	Yes / No	Drug	Yes / No
Antibiotics		Steriods		Sulfinpyrazobne	
NSAIDS		Antiipileptics		Cranberry Juice	
Amiodarone		Cimetidine		Isoniazid	
Aspirin		Dipyridamole		Omeprazole	
Barbiturates		Choestyramine		Paracetamol	
Rifampicin		Griseovulvin		Propranolol	
Sucralfate		Fluconazole		Tramadol	
Phenylbutazon		Glucosimine			
Statins		Levothyroxine			
Antidepressants		St Johns Wart			
Other		Propafenone			

History: (please indicate)

GI Bleed	Yes / No	Malignancy	Yes / No	Hypertension	Yes / No
Alcohol	Yes / No	Renal impairment	Yes / No	Hepatic impairment	Yes / No
Other:					

Once completed please post to: Anticoagulation Service, Unit 7 & 8 Ambley Green, Bailey Drive, Gillingham, Kent. ME8 0NJ

Email: medch.mas@nhs.net

Tel: 01634 382856

For office use only:

Date form received in anti-coagulation service……..……..

Patient contacted Yes / No

Date and time……

By whom:……...

Patient wishes to be seen at: (clinic name)……

Date and time of 1st appointment……

Referral entered onto DAWN software Yes / No

By whom……

Date and time……

Referral incomplete – sent back to referrer Yes / No

Date and time……

By whom……