ANTICOAGULATION MANAGEMENT CLINIC PHYSICIAN REFERRAL FORM
Phone: (360) 863–4680 Fax: (360)794–1490
Please fax completed referral forms to the Anticoagulation Management Clinic

Physician to Complete

Patient Name: ______________________________
Anticipated Date of First Anticoagulation Clinic Visit: ______________________________
Note: Anticoagulation Clinic is closed weekends and holidays
Reason for Anticoagulation: **(include diagnosis code(s))**______________________________
Target INR Range: ______________________________
Anticipated Duration of Anticoagulation: ______________________________
Complicating Factors / Other Diagnoses: ______________________________
____
Referring MD: ______________________________ Phone: ______________________________
Follow–up Physician (if different): ______________________________ Phone: ______________________________
Office Fax Number to send patient information: ______________________________

PLEASE ATTACH
- FACESHEET
- MOST RECENT HISTORY AND PHYSICAL
- OFFICE ANTICOAGULATION FLOW SHEET
- CURRENT MEDICATION LIST

PLEASE COMPLETE THE FOLLOWING INFORMATION

Patient's Contact Telephone Number: ______________________________
Address: ______________________________
____
Date of Birth: ______________________________
Previous Anticoagulation Clinic: ______________________________
Phone: ______________________________

Physician Signature*: ______________________________ **Date:** __________ **Time:** __________

*Signature indicates provider's order for evaluation and management of anticoagulation therapy by EvergreenHealth Monroe Anticoagulation Management Clinic, assignment of benefits for anticoagulation management to EvergreenHealth Monroe and authorization for the use of Washington State Board of Pharmacy approved collaborative management agreement.

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