Anticoagulation Consult Service
Southeastern Regional Medical Center
Pharmacy Department

910-671-5417(phone)
910-735-8094 (fax)

REFERRAL

Patient name_____ DOB_____

Point of contact name_____ (if applicable)

Phone number_____ Alternate number_____

Indication for warfarin_____

ICD-10 Code_____

Expected Duration of therapy_____

PLEASE SPECIFY TARGET INR RANGE

INR target □ 2 – 3 □ 2.5 – 3.5 □ Other_____

Current warfarin dose _____

Most recent INR _____ _____
(INR) (date)

*Comments:*_____

I, _____, authorize the SRMC Anticoagulation
(provider name)
pharmacist(s) to manage warfarin therapy in accordance with the SRMC Pharmacy and Therapeutics committee approved anticoagulation protocol. I deem this service medically necessary. PT/INR may be tested as often as determined necessary by the clinic pharmacist(s). **I understand that this also gives permission for clinic pharmacist(s) to authorize warfarin refills on my behalf.** I agree to notify the Anticoagulation Clinic if this patient is discharged from my care or if warfarin is discontinued.

_____ _____
(provider signature) (date)

_____ _____
(office phone) **(office fax)**

☐ By checking this box and initialing, _____, I state that I **DO NOT** give permission for clinic pharmacist(s) to authorize refills on my behalf.

A copy of the SRMC P & T approved outpatient anticoagulation protocol is available at your request.