



# ANTICOAGULATION CLINIC REFERRAL FORM

## ST. JAMES'S HOSPITAL

NCHCD  
Sep 2011

Attach addressograph:

Consultant Name:

Name:

Ward/Clinic:

MRN:

Patient's phone (home):

DOB:

Patient's mobile:

Address:

**Indication for Anticoagulation:**

**INR Target Range (please circle)**

2.0-3.0

3.0-4.0

*It is strongly advised that patients should receive one of the standard therapeutic ranges for anticoagulation according to the clinical indication. Please discuss **non-standard** therapeutic ranges with the anticoagulation nurse on **bleep 011** in advance of referral.*

**Duration of Anticoagulation (please circle)**

3 months

6 months

Indefinite

Other:

Complete as in patients' anticoagulation book (yellow book)		
Date	INR	Dosage

**Reason for Admission to Hospital:**

**Date Discharged:**

**Next INR required**

**Date:**

**Time:**

**Current Medications (to include anti-platelet therapy, if applicable):**

**Referring Consultant OPD follow up appointment (for review of anticoagulation therapy):** *Yes / No*

*(this section **must** be completed for referral to be processed)*

*Date: \_\_\_\_\_*

**Doctor's Name:**

**Signature:**

**Bleep No:**

**Date:**

**Internal Referrals SJH:** *Please complete and hand deliver before 1630hrs to the Anticoagulation Clinic Nurses Office, located beside Switch/Breast Care. After 1630hrs and at weekends, please fax completed form to 01 4103556 and follow up with a phone call to Ext 4403 **on the next working day**. If you have any queries in relation to the referral process please **Bleep 011** to speak with the Anticoagulation Nurse.*

**External Referrals:** *Please fax completed form to 01 4103556 and follow up with a phone call to 01428 4403 to ensure we have received your referral. Please note that patients referred to the nurse led anticoagulation clinic must be under the care of a consultant in St. James's Hospital.*