National Coagulation Centre

Warfarin Clinic Service- Patient Referral Form

ST JAMES'S HOSPITAL

Name of the Patient: …… **Date of Birth:** ……/ ……. /…….

Patient's Contact Number: ……

Referring Consultant: ……

GP address and contact number:

……

……

Is this patient suitable for Direct Oral AntiCoagulants (DOAC)? **YES** ☐ **NO** ☐

*** If the answer is 'YES' consider switching this patient to DOAC if clinically appropriate, rather than a warfarin clinic referral.**

***If the answer is 'NO', then continue with the Referral and complete the following information.**

Indication for warfarin:

(Please ensure that the patient receives a prescription for at least a one-month supply)

Duration of warfarin therapy:

Please indicate the Target INR level:

When was warfarin started? What is current dose?

Please be aware that sending a referral does not confirm the acceptance of referral/patient care.

- **Once the referral is received, a member of the anticoagulation team will contact to confirm acceptance of the referral you send.**
- **They will also contact the patient directly with an appointment to attend the Anticoagulation clinic.**
- **Please ensure that the patient is provided with sufficient supply of prescription/medication upon discharge.**

Contact Details: ncc@stjames.ie **Telephone: 01428 4403, 01416 2637**

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Is the patient currently on Low Molecular Weight Heparin(LMWH): Yes ☐ **No** ☐

(If on LMWH, please provide the patient with sufficient prescription-at least 7 days)

Will they require bridging with LMWH if sub therapeutic INR in future? Yes ☐ **No** ☐

Attach a copy of the most recent blood results (please complete the following fields)

Date:	**INR**	**Dose advised:**
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Relevant medical history (specify conditions such as the history of bleeding/liver disease/renal impairment/severe hypertension.)

Please list **Current medication:** Medication on discharge (Drug interaction check should use a combination of SmPC, Stockleys or up-to-date Lexicomp interaction drug checker)/ (or **attach a copy of the discharge summary that includes a list of medication on discharge**)

Referral sent by…… **Date ……../……../……**

Name…….

Direct contact number (Referring personnel): Bleep/Landline/Mobile……

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