

Warfarin Clinic Service- Patient Referral Form

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

Referring Consultant:

GP address

.....
.....
.....
.....

Contact number:

Patient Address

.....
.....
.....
.....

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 month's 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:
Date:	INR	Dose advised:
Date:	INR	Dose advised:

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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