National Coagulation Centre

ST JAMES'S HOSPITAL

# Warfarin Clinic Service- Patient Referral Form

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

**Patient's Contact Number:** ……………………………………………………………

**Referring Consultant:** ……………………………………………………………………

**GP address and contact number:**

……………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

**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?**

| |
|---|
| |

**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 subtherapeutic INR in future? Yes ☐ No ☐**

**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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**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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