

Coumadin Clinic

Referral for Medical Therapy Management

Fax: 504.903.1605



Referral from: BMC EKL LJC LAK
 LIH UMC WOM Other: _____

Attending Provider: _____ ID Number: _____

If Label /Stamp is Not Available Complete the Following:

Patient's Name: _____ Date of Referral: _____

Date of Birth: ____/____/____ Medical Record Number: _____

1° Contact Number: _____ 2° Contact Number: _____

Email: _____

Coumadin Clinic DOES NOT INITIATE THERAPY. Referrals are accepted for provision of follow-up monitoring for patients already begun on Coumadin therapy—select from indications below.

Select Reason for Referral and provide ALL requested information below:

451.9 DVT: first episode with:	Desired INR:	Duration of therapy desired:
<input type="checkbox"/> Transient Risk factor:	2.0-3.0	3 months
<input type="checkbox"/> Idiopathic:	2.0-3.0	12 months
<input type="checkbox"/> Diagnosed Malignancy:	2.0-3.0	indeterminate
<input type="checkbox"/> 451.9 Recurrent DVT:	2.0-3.0	indeterminate
<input type="checkbox"/> 427.31 Atrial Fibrillation:	2.0-3.0	indeterminate
<input type="checkbox"/> 415.19 Pulmonary Embolus:	2.0-3.0	≥6 months
<input type="checkbox"/> 289.81 Hypercoagulable Condition:	2.0-3.0	Indeterminate
<input type="checkbox"/> Cardiac Valvular Disease*:	2.0-3.0	Indeterminate

*Includes: 394.1 Rheumatic Mitral valve and 427.31 A Fib or 415.1 Hx of Emboli
394.1 Rheumatic Mitral Valve, Normal Sinus Rhythm (NSR), and LA Diameter >5.5 cm
V43.3 Aortic St. Jude Medical Bi-leaflet valve
V43.3 Aortic Carbomedics Bi-leaflet or Medtronic Hall Tilting Disk valves, no risk factor
V42.2 Bioprosthetic valve (Mitral or Aortic)

Cardiac Valvular Disease**:

	2.5-3.5	Indeterminate
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**includes: v43.3 Mitral tilting disk valves and bi-leaflet mechanical valves
V43.3 Mechanical valves with risk factors (A fib, MI, LAE, endocardial damage, Low EF)
V43.3 Mechanical valve with breakthrough embolism despite INR 2.0-3.0

Other: ICD 9: _____ Diagnosis: _____

Date anticoagulation was begun: ____/____/____ [Check here if unknown:

Current anticoagulation dose & frequency: _____

Most recent PT: ____ INR: ____ Date: ____/____/____ (IF UNKNOWN Please order PT, INR now)

Date of documented negative pregnancy test for women of child bearing age: ____/____/____

Referring Provider's Signature: _____ ID Number: _____

Contact Number: _____ Referring Service/Clinic: _____

Fax Number: _____ Email: _____

OFFICE USE ONLY: Appointment Date: ____/____/____ Time: __:__ am/pm.

If not scheduled, Indicate Reason & Recommendation: _____

Reviewing Provider's Signature: _____ ID Number: _____

Contact Number: _____

Rev 2/19/09