**ANTICOAGULATION SERVICE REFERRAL – Oxford Haemophilia & Thrombosis Centre **

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s name: | | | | | | | | | | | Date of Birth: | | | Gender: | | |
|  | | | | | | | | | | |  | | | **M / F** | | |
| NHS number: | | | | | |  | Address: | | | | | | | | | |
|  | | | | | |  |
| Telephone number: | | | | | |  |
|  | | | | | |  | Post code: | | | | | | | | | |
| ( Please note that unless you advise otherwise we will assume that the patient agrees we can leave messages at this number) | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| INR target (please circle): | | | **2.5 (2.0-3.0)** | | | | | | **3.0 (2.5-3.5)** | | | **3.5 (3.0-4.0)** | | | | |
| Duration of therapy (please circle): | | | **3 months** | | | | | | **6 months** | | | **Indefinite** | | | | |
|  | | | | | | | | | | | | | | | | |
| **Reason for anticoagulation:** | | | | | | | | | | | | | | | | |
| **Atrial fibrillation**  (for induction\*)  **Atrial flutter**  (for induction\*)  \*AC service will initiate slow loading with warfarin |  |  | | | Please prescribe warfarin (1mg, 3mg & 5mg) and send baseline INR, instruct patient not to start until contacted by AC service  Please indicate stroke / TIA history:  **KNOWN STROKE/TIA**  **NO KNOWN STROKE/TIA**  If target INR other than 2.5 (2.0-3.0) please indicate reason. | | | | | | | | | | | |
| **Deep Vein Thrombosis**  **Pulmonary Embolism** |  | | | | **Date of diagnosis:**  Patients seen at the Churchill DVT clinic do *not* need a referral; they will be automatically transferred to RAID dosing system on completion of induction. | | | | | | | | | | | |
| **Other indication** |  | | | | Please give details here: | | | | | | | | | | | |
| **Additional information:** | | | | | | | | | | | | | | | | |
| Is patient receiving low molecular weight heparin (LMWH)? |  | | | | Generally patients will not be accepted by the Anticoagulation Service while still on LMWH. If you have ticked yes please contact the Anticoagulation Service *before* referring the patient. | | | | | | | | | | | |
| Anticoagulant drug = Warfarin |  | | | | If other than warfarin please indicate here: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Previous / Current INR and dosing information** | | | | | | | | | | | | | | | | |
| (please tick here if induction for AF is required & we will initiate slow loading of 3mg per day for 4-7 days) | | | | | | | | | | | | | | | | |
|  | | | | **Date** | | | | | | **INR** | | | **Dose** | | | |
| **Last visit** | | | |  | | | | | |  | | |  | | | |
| **2** | | | |  | | | | | |  | | |  | | | |
| **3** | | | |  | | | | | |  | | |  | | | |
| **4** | | | |  | | | | | |  | | |  | | | |
|  | | | | | | | | | | | | | | | | |
| **Next INR request date / date of baseline INR:** | | | | | | | | | | | | | | | | |
| Please give details of any other medical complications: | | | | | | | | | | | | | | | |  |
| Please list any other medication the patient is taking (including OTC medicines): | | | | | | | | | | | | | | |  | |
| **Any other requirements? Email DN Email Community Phlebotomist Other**  Give details: | | | | | | | | | | | | | | | | |
| Signature: | | | | | | | | Date: | | | | | | | | |
| Referring Physician: | | | | | | | | GP Practice: | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **Email to: ac.referral@nhs.net for Oxford *or* orh-tr.achgh@nhs.net for Banbury by 12:00pm on day dosing required** | | | | | | | | | | | | | | | | |
| Anticoagulation Service, Oxford Haemophilia & Thrombosis Service, OX3 7LJ. Version 12, November 2017 | | | | | | | | | | | | | | | | |
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