

ANTICOAGULANT REFERRAL

SURNAME: _____ HOSP NO: _____

FIRST NAMES: _____ DOB: _____

HOME ADDRESS: _____

POSTCODE: _____

TEL. NO: _____

INDICATION FOR ANTICOAGULATION

- ☐ AF ☐ AF for DCCV
☐ DVT ☐ PE
☐ Mech bileaflet aortic valve
☐ Mech caged ball aortic valve
☐ Mechanical mitral valve
☐ Mitral valve repair
☐ Other (please specify) _____

DURATION OF THERAPY

- ☐ 3 months
☐ 6 months
☐ Lifelong
☐ Other (specify) _____

WARFARIN DOSING HISTORY:

DATE	INR	DOSE

TINZAPARIN DOSE and weight

DATE OF DVT/PE/STROKE:**NEW DIAGNOSES:**

PATIENT SUITABLE FOR SLOW LOADING? (ON AVERAGE TAKES 4 WEEKS UNTIL INR>2)

YES ☐ NO ☐

MEDICATIONS:

FAXED TTO ☐ DATE _____

***ALREADY with Community Pharmacy Service** ☐ Yes ☐ No

Spouse/carer gives meds: ☐ Yes ☐ No

Transport: ☐ Not required ☐ Hospital car
☐ 1 man ambulance ☐ 2 man ambulance

DOCTOR'S NAME:
(SIGN & PRINT):

BLEEP:

DATE: ____/____/____

FAXED: ____/____/____

1. **INR** must be checked within **FOUR days** of discharge for all patients on warfarin
2. Discharge is not recommended if INR is greater than 5.0.
3. **A referral form must be filled out** for all patients on warfarin including those managed in the community prior to hospital admission. Onward referral to the local community anticoagulation services for RSCH catchment area will be made by the hospital laboratory as appropriate.

The discharge referral pathway depends on where your patient lives:

Brighton and Hove patients: Fax this referral form to 01273 664977. The RSCH anticoagulation clinic only runs on **Mondays and Thursdays**. For Bank Holiday Mondays or if a blood test is due any other day, the patient should return to the ward for an INR and dosing by the ward doctor.

Mid-Sussex and any other location: Fax this referral form to the patient's **GP or to their regional anticoagulation clinic** and **telephone to confirm** receipt of form and details of appointment to communicate to patient before they are discharged. For all patients living in the **Worthing** area, please fax the referral to **Worthing Hospital Anticoagulation Clinic** on 01903 285037 (includes existing patients)

The discharging doctor is responsible for the patient's care until follow-up monitoring is arranged.

	Range	Duration
Atrial Fibrillation (AF)	2.0 – 3.0	lifelong
AF for DCCV (cardioversion)	2.5 – 3.0	until notified by cardiology
Mechanical bileaflet aortic valve	2.5 – 3.5	lifelong
Mechanical caged ball aortic valve	3.0 – 4.0	lifelong
Mechanical mitral valve	3.0 – 4.0	lifelong
Mitral valve repair	2.0 – 3.0	3 months
Mitral stenosis or regurgitation with AF, history of systemic embolism, Left atrial thrombus or enlarged left atrium	2.0 – 3.0	Consultant cardiologist decision
Cardiomyopathy	2.0 – 3.0	lifelong
Antiphospholipid Syndrome (APS) with thrombotic event requiring treatment	2.0 – 3.0	lifelong
APS with recurrent VTE whilst on warfarin with therapeutic INR	usually 3.0 – 4.0	Discuss with haematologist
Treatment of first VTE event	2.0 – 3.0	3 months calf DVT 6 months femoral/iliac DVT/PE
Treatment of single VTE episode provoked by surgery or non-transient risk factor	2.0 – 3.0	3-6 months
Treatment of single unprovoked VTE episode	2.0 – 3.0	Consultant decision Consider lifelong
Treatment of recurrent VTE when not anticoagulated/subtherapeutic INR	2.0 – 3.0	Consider long term
Treatment of recurrent VTE whilst on warfarin with therapeutic INR at time of event	3.0 – 4.0	Lifelong

This request must be COMPLETED IN FULL, IN BLACK INK and faxed to Coagulation (4977) before appointment can be made. Incomplete forms will not be appointed.