GP Referral Form: Community Pharmacy Anticoagulation Management Services

PATIENT IDENTIFICATION					
SURNAME		First Name		PHN	
Date of Birth:				Age:	
Street Number & Name:					
City/Town:			Postal Code:		
Email:					

Home phone		Cell		Work phone	

MEDICATION INFORMATION

INDICATION	√
Atrial Fibrillation	
Deep Vein Thrombosis	
Pulmonary Embolism	
Tissue Heart Valve	
Mechanical Valve Prosthesis	
Mural Thrombus	
TIA	
Myocardial Infarction	
Other	

TARGET INR:	√
2.5 (2.0-3.0)	
3.0 (2.5-3.5)	
Other ________________	

DATE WARFARIN STARTED (OR DATE THERAPY TO COMMENCE)

ANTICIPATED DURATION:	
Lifetime	

WARFARIN BRAND AND STRENGTH	√
Brand of Warfarin:	
Use 1 mg tabs only	
Use 2 mg tabs only	
Split tablets	

PATIENT ACCESS: Is the patient able to view their results on line?	√
Yes	
No	

THREE MOST RECENT WARFARIN DOSES		
Date of INR test	INR Result	Warfarin Dose

PRESCRIPTION: Confirm that the prescription for warfarin will be in accordance with the "Standing Orders for the Management of Warfarin: dose adjustment and INR testing frequency". [If not done already, this Standing Order needs to be signed and sent to the pharmacist who will manage this patient].	Yes / No

TEST FREQUENCY:

N.B. The maximum default test frequency of 28 days will be used unless otherwise specified by the referring doctor.

Monthly INR tests **(DEFAULT**)	
Six weekly INR tests	
Other test frequency	

CAUTIONS: Please indicate if the patient has any of the following:		
Problems with excess alcohol intake	Yes	No
Persistent unstable INRs	Yes	No
Details and Additional Cautions:		

REFERRING GP DETAILS			
Dr			
Clinic		Fax	
Email			
Street Number & Name			
City/Town		Postal Code	
Phone:		Cell phone	

Signed			
Full Name		Date	

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