

WARFARIN (COUMADIN) THERAPY REFERRAL

PATIENT INFORMATION			
Patient Name	Height:	Weight:	ID Number
Address	City/State/Zip		
Phone	Start of Care		
Primary Caregiver Name/Relationship			Phone
Diagnosis(es) (include ICD-(code):			
Warfarin therapy starting date: _____ Initial Dose: _____ Current Dose(s) and Frequency: _____			
Most Recent: INR: _____ Date: _____ PTT: _____ Date: _____			
Goal: <input type="checkbox"/> INR = 2.0-3.0 <input type="checkbox"/> INR = 2.5-3.5 <input type="checkbox"/> PTT = _____ (specify) <input type="checkbox"/> Other _____			
LABS REQUESTED			
<input type="checkbox"/> INR (preferred) or P.T.: _____		<input type="checkbox"/> AST: _____ ALT: _____	
<input type="checkbox"/> CBC: _____		<input type="checkbox"/> Bilirubin: Direct: _____ Indirect: _____	
<input type="checkbox"/> Serum Albumin: _____		<input type="checkbox"/> Homocysteine Serum Concentration: _____	
<input type="checkbox"/> BUN: _____		<input type="checkbox"/> Serum Na: _____ K: _____ Cl: _____	
<input type="checkbox"/> Serum Creatinine: _____		<input type="checkbox"/> Serum Ca: _____ CO2: _____	
<input type="checkbox"/> 1,25 – dihydroxyvitamin D (if available) _____			
REASON FOR REFERRAL (OPTIONAL)			
REFERING GROUP INFORMATION			
Referred From:			Discipline:
Address:		City/State/Zip:	
Date of Referral:		Phone:	
Name and Signature of Person Completing This Form			Date