

**GP Referral Form: Community Pharmacy Anticoagulation Management Services**

PATIENT IDENTIFICATION					
SURNAME		First name(s)		NHI	
Date of Birth:				Age:	
Street Number & Name:					
Suburb:					
City/Town:			Postcode:		
Email:					

Home phone		Cell		Work phone	
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MEDICATION INFORMATION			
<b>INDICATION</b>	√	<b>TARGET INR:</b>	√
Atrial Fibrillation		2.5 (2.0-3.0)	
Deep Vein Thrombosis		3.0 (2.5-3.5)	
Pulmonary Embolism		Other _____	
Tissue Heart Valve		<b>DATE WARFARIN STARTED (OR DATE THERAPY TO COMMENCE)</b>	
Mechanical Valve Prosthesis			
Mural Thrombus		<b>ANTICIPATED DURATION:</b>	
TIA			
Myocardial Infarction		Lifetime	
Other			
<b>WARFARIN BRAND AND STRENGTH</b>	√	<b>PATIENT ACCESS:</b> Is the patient able to view their results on line?	√
Marevan: Only use 1mg tabs		Yes	
Marevan: Use 1mg, 3mg and 5mg tabs		No	
Marevan: Other			
Coumadin: Only use 1mg tabs			
Coumadin: Use 1mg, 2mg and 5mg tabs			
Coumadin: Other			

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

**PRESCRIPTION:** Confirm that the prescription for warfarin will be according to the “Standing Orders for the Management of Warfarin: Dose adjustment and INR testing frequency”. [If not already, this Standing Order needs to be signed and sent to the pharmacy who will manage this patient].

Yes / No

**TEST FREQUENCY:**

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

Monthly INR tests ( <b>DEFAULT</b> )	
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
<u>Details and Additional Cautions:</u>		

**REFERRING GP DETAILS**

Dr

Surgery

Fax

Email

Street Number & Name

Suburb

City/Town

Postcode

Phone:

Cell phone

Signed

Full Name

Date