Your PHARMACY
Mount Maunganui

# *Referral Form for Pharmacy-led Anticoagulation Management Service*

| PATIENT IDENTIFICATION | |
|---|---|
| Name: | |
| Date of Birth: | Age: |
| NHI Number: | |
| Street Number & Name: | |
| Suburb: | |
| City/Town: | Postcode: |
| Home Phone: | |
| Work Phone: | |
| Cell Phone: | |
| Email Address: | |

**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:_____

**WARFARIN BRAND USED:**

| **Marevan** | **Coumadin** |
|---|---|
| □ | □ |

**ANTICOAGULATION THERAPY STARTED ON (DATE): _____**

**ANTICIPATED DURATION:**
- □ 6 weeks
- □ 3 months

Your Pharmacy Mount Maunganui
42 Girven road
Mount Maunganui
PO BOX 10022
Phone: 64 7 574 8645 Fax: 64 7 574 8645

□ 6 months
□ 1 year
□ life-time

**PATIENT ACCESS**

Allow patients to view their own results on line? □ No
□ Yes

**3 MOST RECENT INR RESULTS & WAFARIN DOSES:**

| Date of INR test | INR Result | Warfarin Dose |
|---|---|---|
| | | |
| | | |
| | | |

**PRESCRIPTION:** According to the Standing Order for the Management of Warfarin Dose adjustment and INR testing frequency.

**CAUTIONS**

Please indicate if your patient has any of the following:

Problems with excess alcohol intake □ No □ Yes
Persistent unstable INRs □ No □ Yes

| Details and Additional Cautions: |
|---|
| |

| Dr: | |
|---|---|
| Surgery: | |
| Street Number & Name: | |
| Suburb: | |
| City/Town: | Postcode: |
| Phone: | |
| Fax: | |
| Cell Phone: | |
| email: | |

Signed: _____

Date: _____

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