**ANTICOAGULATION SERVICE REFERRAL – Oxford Haemophilia & Thrombosis Centre **

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| --- | --- | --- |
| Patient’s name: | Date of Birth: | Gender: |
|  |  | **M / F** |
| NHS number: |  | Address:  |
|  |  |
| Telephone number: |  |
|  |  | Post code: |
| ( Please note that unless you advise otherwise we will assume that the patient agrees we can leave messages at this number) |
|  |
| INR target (please circle): | **2.5 (2.0-3.0)** | **3.0 (2.5-3.5)** | **3.5 (3.0-4.0)** |
| Duration of therapy (please circle): | **3 months** | **6 months** | **Indefinite** |
|  |
| **Reason for anticoagulation:** |
| **Atrial fibrillation**(for induction\*)**Atrial flutter**(for induction\*)\*AC service will initiate slow loading with warfarin |  |  | Please prescribe warfarin (1mg, 3mg & 5mg) and send baseline INR, instruct patient not to start until contacted by AC servicePlease indicate stroke / TIA history: **KNOWN STROKE/TIA**  **NO KNOWN STROKE/TIA** If target INR other than 2.5 (2.0-3.0) please indicate reason.  |
| **Deep Vein Thrombosis** **Pulmonary Embolism** |  | **Date of diagnosis:**Patients seen at the Churchill DVT clinic do *not* need a referral; they will be automatically transferred to RAID dosing system on completion of induction. |
| **Other indication** |  | Please give details here: |
| **Additional information:** |
| Is patient receiving low molecular weight heparin (LMWH)? |  | Generally patients will not be accepted by the Anticoagulation Service while still on LMWH. If you have ticked yes please contact the Anticoagulation Service *before* referring the patient. |
| Anticoagulant drug = Warfarin |  | If other than warfarin please indicate here: |
|  |
| **Previous / Current INR and dosing information**  |
| (please tick here if induction for AF is required & we will initiate slow loading of 3mg per day for 4-7 days) |
|  | **Date** | **INR** | **Dose** |
| **Last visit** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
|  |
| **Next INR request date / date of baseline INR:** |
| Please give details of any other medical complications: |  |
| Please list any other medication the patient is taking (including OTC medicines): |  |
| **Any other requirements? Email DN Email Community Phlebotomist Other**  Give details:  |
| Signature: | Date: |
| Referring Physician: | GP Practice: |
|  |
| **Email to: ac.referral@nhs.net for Oxford *or* orh-tr.achgh@nhs.net for Banbury by 12:00pm on day dosing required** |
| Anticoagulation Service, Oxford Haemophilia & Thrombosis Service, OX3 7LJ. Version 12, November 2017 |
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