MercyOne Siouxland Ambulatory Pharmacy (MOSAP)
Anticoagulation Referral Form

Phone: 712-279-2460 Fax: 712-279-2463 Email: MOSAP@mercyhealth.com

Patient Name:_____ **DOB:**_____/_____/_____

Address:_____ **Phone Number:** _____

Primary Care Provider:_____

The clinic will be unable to schedule initial appointments without receipt of this referral form **signed** and **dated by the referring provider.** Please fax completed form to (712) 279-2463. Upon receipt of referral form, we will contact the patient to schedule the initial visit.

Warfarin Indication

- ❑ **Deep Vein Thrombosis**
  - ❑ 1st Time ❑ Recurrent
- ❑ **Pulmonary Embolus**
  - ❑ 1st Time ❑ Recurrent
- ❑ **Valve Replacement**
  - ❑ Mechanical ❑ Bioprosthetic
- ❑ **Atrial Fibrillation**
- ❑ **Post-Surgical Prophylaxis**
- ❑ **Other:** _____

Duration of Therapy: ❑ **Indefinite** ❑ **3 months** ❑ **6 months** ❑ **Other (specify)**_____

Target INR Goal: ❑ **2.0 - 3.0** ❑ **2.5 - 3.5** ❑ **Other:**_____

Warfarin Start Date:_____

Current warfarin dosage (if already started):_____

Most recent INR and date:_____

Currently taking aspirin, clopidogrel etc? _____

Currently bridging with enoxaparin/heparin/other:_____

- **By my signature, I understand this patient will have his or her warfarin and/or LMWH therapy managed by an authorized pharmacist of the MercyOne Siouxland Ambulatory Pharmacy (MOSAP) according to established policies and procedures. I will continue following this patient for anticoagulation therapy until the MOSAP Clinic establishes care, and I will resume care if necessary based on discussion between provider and MOSAP Clinic pharmacist. In addition, I grant prescriptive authority for warfarin/low-molecular-weight heparin/Vitamin K under my name and authority to bill each visit. I consider this care to be medically necessary for this patient.**
- **The pharmacist may order appropriate laboratory measurements and schedule clinic visits according to patient needs within the guidelines of the policies and procedures of the MOSAP anticoagulation service.**
- **My staff will communicate any known upcoming procedures which may impact warfarin management to the MOSAP clinic.**
- **The MOSAP Clinic will fax the progress notes to the referring and/or primary care provider after each visit for review.**
- **In the event the pharmacist identifies a clinical concern and the primary care provider is not immediately available, the concern will be brought to the attention of the MOSAP medical director or Emergency Department provider.**

Provider's Signature:_____ **Date:**_____

(Authorizes Anticoagulation Pharmacist involvement according to standard of care and policies and procedures.)