NYU Langone Health
Anticoagulation Service Referral Form

Phone: (212) 263-0980 | **Fax:** (929) 455-9066

Patient Demographics * *(required)*

Last Name: _____

First Name: _____ Date of Birth: _____

Home Address: _____

_____

Telephone Number: _____ Alternative Phone Number: _____

Insurance Info* *(required)*

Insurance Company:_____

Policy Holder's Full Name: _____

Relationship to Patient:_____

Member ID / Policy Number: _____

Diagnosis (Please Check All That Apply * *(required)*

- ☐ Aortic Mechanical Heart Valve
- ☐ Atrial Fibrillation
- ☐ CTEPH
- ☐ CVA / TIA
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Heart Failure with reduced EF
- ☐ Mitral Mechanical Heart Valve
- ☐ Mural Thrombosis
- ☐ Peripheral Vascular Disease PVD)
- ☐ Pulmonary Embolism (PE)
- ☐ Transplant List Candidate

Hypercoagulable State:

- ☐ Antiphospholipid Syndrome
- ☐ Factor V Leiden
- ☐ Protein C deficiency
- ☐ Protein S deficiency

☐ Other: _____

Target INR Range * *(required)*

- ☐ 1.5 - 2.0
- ☐ 2.0 - 3.0
- ☐ 2.5 - 3.5
- ☐ Other: _____, please specify reason: _____

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Recent Warfarin Dosing / INR History *(if applicable)*

Most Recent INR: _____ Date: _____

Current Warfarin Dose: _____ Tablet Strength Used (mg): _____

Currently on LMWH? ☐ Yes ☐ No

LMWH Dose: _____

Duration of Therapy * *(required)*

☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Lifelong ☐ Other: _____

PERTINENT PAST MEDICAL / SOCIAL HISTORY * *(Check all that apply)*

☐ Alcohol Abuse
☐ Anemia
☐ CAD
☐ Diabetes
☐ Heart Failure
☐ Hepatic Insufficiency
☐ HIT (Heparin Induced Thrombocytopenia)
☐ History of GI Bleed
☐ History of ICH (Intra-cranial Hemorrhage)
☐ HTN (Hypertension)
☐ Malignancy
☐ Previous CVA
☐ Renal Insufficiency
☐ Thrombocytopenia
☐ Other: _____

Bridging / LMWH Requirements * *(required)*

Bridging for procedures required? ☐ Yes ☐ No

Subtherapeutic INRs:
LMWH required if INR below threshold? ☐ Yes ☐ No

***If yes,** threshold INR: _____

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To Be Completed by Referring Provider or Specialist * *(required)*

All peri-procedural anticoagulation plans are forwarded to both the referring provider and proceduralist for recommendations and final approval. Plan will be communicated to patients and monitored by NYU Langone Health Anticoagulation Service providers.

By signing and submitting this form I authorize the NYU Langone Health Anticoagulation Service to perform warfarin therapy monitoring and dose adjustments for the above-named patient per their established policies/procedures.

Printed Name: _____ **Signature:** _____

Practice Name:

_____

Practice Address:

_____

_____

Telephone Number: _____ **Fax Number:** _____

☐ **Routine requests** *(seen within two weeks)*
☐ *Urgent requests (seen within 48 hours)*

Fax the following patient documents to expedite referral for urgent requests

☐ Last INR ☐ CBC ☐ CMP ☐ Progress Note

ATTN: NYU Langone Health Anticoagulation Service

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