PENINSULA CARDIOLOGY ASSOCIATES, P.A.
COUMADIN CLINIC REFERRAL FORM
Salisbury Clinic Phone No. 410 543-1810 Fax No. 410 543-1251
Berlin Clinic No. 410 641-3794 Fax 410 641-1693

Referral process:

1. Please complete form. **INCOMPLETE** forms will **NOT** be accepted.
2. The following may sign the order: M.D., D.O., P.A., N.P., or PCA R.N.
3. Give patient the initial dosing instructions and indicate below before referring the patient.

_____New patient OR _____Re-enrollment

Patient Name_____ SSN_____
Address _____ Sex ( ) Male( ) Female Date/Birth_____
_____ Home phone_____
_____ Work or Cell _____
Contact person (if other than patient)_____ Phone_____
Type of insurance_____

ANTICOAGULATION DIAGNOSIS_____

DATE OF PROCEDURE OR ONSET OF ILLNESS_____
_____Acute _____Chronic

INR Range

( )	2-3	For atrial fib, DVT, PE, cardiomyopathy, CAD or PVD
( )	2.5 – 3.5	For mechanical valve replacement or some coagulopathies
( )	3 – 4	Suggested range for positive antiphospholipid antibody syndrome

Expected length of therapy _____lifetime _____6 months _____3 months
If Atrial fibrillation, is cardioversion anticipated? _____yes _____no
Is patient to be on Aspirin and Coumadin concomitantly _____yes _____no

IF THIS PATIENT HAS A DVT Where _____ **( ) left ( ) right ( ) bilateral**
IF THIS PATIENT HAS A PE ( ) post –op or ( ) spontaneous
Dosing instructions_____
Tablet strength _____Next INR to be drawn on _____by the Coumadin Clinic or
_____Home health agency Name of agency_____

Last INR's	Date	INR
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

SIGNATURE _____ **DATE**_____