TITLE: **ANTICOAGULATION REFERRAL ORDERS FOR PHARMACY OUTPATIENT CARE CENTER**

NOTE: ☑ THESE ORDERS CAN BE CHECKED BY THE PHYSICIAN TO DESIGNATE FURTHER INSTRUCTIONS. THESE ORDERS WILL BE FOLLOWED UNLESS CROSSED OUT.

DO NOT USE THE FOLLOWING ABBREVIATIONS: U or u; Q.D., QD, q.d., qd; Q.O.D. QOD, qod, q.o.d., IU, MS or MSO4 or MgSO4; trailing zero; lack of leading zero

1. ☑ By this referral, I understand that my patient will have their anticoagulant and/or LMWH therapy managed by the pharmacist of the Mount Carmel Pharmacy Outpatient Care Center according to established policies and procedures. I will resume care if required by established policies and procedures. In addition, I grant prescriptive authority for these agents under my name, authorize the pharmacist to order oral vitamin K according to the protocols when needed, and allow the clinic to act as an agent to initiate and execute the insurance prior authorization process. I concur with these guidelines and permit their implementation in this patient. I consider this program to be a necessary part of the patient's medical care.

PLEASE PRINT THE FOLLOWING INFORMATION:

Patient name _____ Phone _____

Date of birth _____

Last 4 digits of Social Security _____

Insurance _____

Anticoagulation diagnosis_____

Current warfarin (Coumadin®) dose and schedule _____

or DOAC Name, dose and schedule_____

Intended length of therapy: _____Months or _____ Long term (current) use of anticoagulants [Z79.01]

PLEASE FAX OR WRITE THE LAST FIVE INRs IF AVAILABLE

INR _____ Date/Time _____ INR _____ Date/Time _____ INR _____ Date/Time _____

INR _____ Date/Time _____ INR _____ Date/Time _____

Next appointment date _____

Physician (please print)_____ Phone _____

Fax _____

Please fax this form to the appropriate Pharmacy Outpatient Care Center:

☐ Mount Carmel East	☐ Mount Carmel St. Ann's	☐ Mount Carmel Grove City
614-234-8844 phone	380-898-6020 phone	614-663-4995 phone
614-234-8850 fax	380-898-6021 fax	614-663-4994 fax

Physician Signature _____ Date _____ Time _____

Mount Carmel, Columbus, Ohio

Preprinted Physician Orders

1951-5-22

NAME

DOB

MR #

FIN #