Anticoagulation Center - Referral Form

Office #: (269) 341-7909
Fax #: (269) 341-7648

Bronson Medical Office Pavilion
601 John St., Suite M-425

Dear Provider:

Please complete this form when referring a patient on anticoagulation therapy to Bronson's Anticoagulation Center.

Completed forms can be faxed or mailed to the Anticoagulation Center.

Thank you for this referral.

Patient Name: ____________________ Date of Birth: __________
Patient Phone Number: __________ (Home): __________ (Work): __________
Patient Address: ____________________
____
____

Anticoagulant Medication: __________
Current Dosage: __________
Desired INR or APTT Range: __________
Therapy Start Date: __________
Expected Length of Therapy: __________
Anticoagulation Diagnosis: __________

Provider Who Will Follow Patient for Anticoagulation Therapy
Name: __________
Address: __________
Phone #: __________
Fax #: __________

Comments:
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____

By my signature, I authorize the Bronson Anticoagulation Center Staff, according to established policies, procedures and protocols to dose my patient (named above) on warfarin (or heparin) and grant prescriptive authority for these agents. In the case of elevated PT/INR, I authorize the Bronson Anticoagulation Staff to give my patient oral vitamin K, according to these protocols. The Anticoagulation Center Staff may schedule appropriate laboratory measurements (PT/INR, APTT,CBC, serum creatinine, pregnancy, fecal occult blood test), and schedule clinic visits according to patient needs within the guidelines of the clinic policies and procedures. I consider this program to be a necessary part of this patient's medical care.
Please fax to (269) 341-7648

Referring Provider Signature: ____________________ Date: __________ Time: __________

Printed Provider Name ____________________