Anticoagulation Referral Form

Guy's and St Thomas' Hospital, King's College Hospital, Princess Royal University Hospital and St George's Hospital

PLEASE COMPLETE ALL INFORMATION IN THE BOXES BELOW

Patient information	Practice information
First Name:	Referring GP Name:
Surname:	Address:
Sex:	
Date of Birth:	
NHS number:	
Address:	GP Practice Code:
	Telephone Number:
	Email Address:
Telephone number: Mobile:	
Email address:	
Ethnicity:	
Main spoken language:	
Interpreter Required? Y ☐ N ☐	
Is the patient a carer? Y ☐ N ☐	
Does the patient have a carer? Y ☐ N ☐	
(If so, provide carer's contact telephone number:)	

Reason for referral	Please select
1. Patient suitable for anticoagulation. Please initiate Direct Oral Anticoagulant (DOAC) or Vitamin K antagonist (VKA).	☐
2. Anticoagulation recommended/indicated but specialist review required before initiation (e.g. prior bleeds, cancer etc. – please give details in further information section)	☐
3. For consideration of switching anticoagulation (e.g. VKA to a DOAC, Low Molecular Weight Heparin to an oral anticoagulant or vice versa)	☐
4. Transfer of anticoagulation service provider **Transfer from [insert previous service provider] to [insert proposed new service provider]**	☐
5. Review of anticoagulation e.g. to review duration of treatment	☐

Reason for anticoagulation		Please select		
Atrial Fibrillation/Flutter		☐	CHA_2DS_2VASC score	HASBLED score
VTE	a) DVT treatment	☐	Date of diagnosis:	
	a) PE treatment	☐	Duration of therapy (if known):	
	a) VTE prophylaxis	☐		
Mechanical Valve Replacement (Please specify type/position at end of form)		☐	INR range:	
Other (specify):		☐	Details:	

Background Information

Diagnostic test results: Weight, height, BMI and Blood Pressure

Weight

Height

BMI

Blood Pressure

Recent bloods: (Hb, platelets, INR, APTTR, Cr, Urea, eGFR, bilirubin, albumin, AST or ALT if available)

Hb

Platelets

INR

APTTR

Cr

Urea

eGFR

Bilirubin

Albumin

AST

ALT

For AF patients provide an echo report, if available.

PMHx: (current and significant past problems)

Allergies:

Current medications:

Does the patient have a dosette box? **Y** ☐ **N** ☐

Concurrent antithrombotic therapy

Is the patient on an antiplatelet? (e.g. aspirin, dipyridamole, clopidogrel, prasugrel, ticagrelor)		**Yes** ☐ **No** ☐
IF YES	**Name of antiplatelet:**	
	Indication:	
	Date initiated:	
	Duration of antiplatelet treatment:	
	If long term, is there a compelling reason to continue?	

Complete this section if patient is currently on anticoagulation (any)

Drug name		
Dose and frequency		
For VKA only	Last INR and date	
	Date next INR due	

Further Information (E.g. nature of prior bleeds, types/position of mechanical valve(s), planned interventions, surgery, DCCV)

Name of Referrer:	Date of Request: 12-Apr-2017

Please send the referral by email to:

GSTFT: gst-tr.anticoag@nhs.net
PRUH: kch-tr.br-anticoag@nhs.net
KCH: kch-tr.dh-anticoag@nhs.net
St Georges: stgh-tr.referral.anticoag@nhs.net

Please provide FULL information and attach relevant reports. Incomplete forms will be returned for completion.

Accessible Information Needs (AIS):

LAM1570