ANTICOAGULANT MONITORING SERVICE REFERRAL FORM

HAEMATOLOGY DEPARTMENT
ST MICHAEL'S HOSPITAL

Patient Name: _____

Address: _____

Date of Birth: _____

Hospital No.: _____

Patients Phone No.: _____ Mobile / 2nd contact No.: _____

Referring Consultant: _____ Ward: _____

G.P's Name: _____ Phone No.: _____

Address: _____

Indication for Anticoagulant: _____

Is this the 1st episode: Yes ❑ No ❑ Name of Anticoagulant: _____

Date commenced: _____ Initial Dose: _____ Target INR: _____

Please give details if target INR is different to BCSH Guidelines overleaf:

Duration of anticoagulation: 3 Months 6 Months Permanent

Previous INR and dosing information:

	Date	INR	Dose
Most Recent Visit			
Previous Visit			
Previous Visit			
Previous Visit			

Date of Next Blood Test Appointment: _____ (Please give to patient)

Requesting Doctor (Block Capitals): _____ Bleep No.: _____

Signature _____ SHO/REGISTRAR/CONSULTANT Date: _____

NOTE: REFERRALS WILL ONLY BE ACCEPTED IF COMPLETED IN FULL AND DELIVERED PRIOR TO THE PATIENT ATTENDING.

Form 344