Anticoagulation Clinic

Initiation of Therapy Order Form

Salem Health® Hospitals & Clinics

ENCOUNTER FOR THERAPEUTIC DRUG MONITORING · LONG TERM *(CURRENT)* USE OF ANTICOAGULANTS

PATIENT INFORMATION

Date: ____ /____ /____

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

DIAGNOSIS SUPPORTING ANTICOAGULATION THERAPY (MUST CHOOSE ONE OR MORE)

DVT: Current: Upper Extremity ____ Right, Left, Bilateral (*Please circle one*) ☐ Acute or ☐ Chronic ICD-10: _____

Lower Extremity ____ Right, Left, Bilateral (*Please circle one*) ☐ Acute or ☐ Chronic ICD-10: _____

History of DVT (Z86.718): _____

Other: _____ ICD-10: _____ Specific Location: _____

PE: Acute PE (I26.99): _____ Chronic PE (I27.82): _____ Unspecified PE (I26.99): _____

Personal history of PE (Z86.711): _____ Other: _____ ICD-10: _____

ATRIAL FIBRILLATION: ☐ Persistent *(more than 1 year)* (I48.11) ☐ Other Persistent (I48.19)

☐ Permanent *(cardioversion not indicated)* (I48.21) ☐ Unspecified chronic (I48.20)

☐ Paroxysmal (I48.0) ☐ Unspecified/Other (I48.91)

HISTORY CVA/TIA: ☐ (Z86.73) _____

☐ **MVR** ☐ **AVR, OR** ☐ **BOTH** (*Please check one*) ☐ Prosthetic *(mechanical)* (Z95.2) ☐ Xenogenic *(tissue)* (Z95.4)

☐ Valve Repair (Z48.812) Other: _____ ICD-10: _____

COAGULOPATHY: ☐ Antiphosholipid Antibody (D68.61) ☐ Factor V Leiden (D68.51)

☐ Protein C or S Deficiency (D68.59) Other: _____ ICD-10: _____

OTHER: *(LV Thrombus, Peripheral Vascular Disease, Pulmonary Hypertension)*

Diagnosis: _____ ICD-10: _____

ANTICOAGULANT: ☐ Warfarin

☐ Warfarin and low molecular weight heparin or factor Xa inhibitors

(for initial induction of warfarin or post hospital; includes lab order for creatinine prn)

INR GOAL: ☐ 1.5-2.5 ☐ 2.0-3.0 ☐ 2.5-3.5 ☐ Other: _____

DURATION: ☐ ____ week ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months*

(* *orders are good for up to 12 months maximum*)

Clinic staff may call prescriptions to outpatient pharmacies for warfarin, low molecular weight heparin, oral vitamin K or factor Xa inhibitors under the prescribing provider.

Your signature indicates that you have reviewed current Salem Health Anticoagulation Clinic dosing and management protocol *(https://www.salemhealth.org/services/heart/services/anticoagulation-clinic)*

LICENSED PRACTITIONER SIGNATURE

_____ _____

Signature (*no signature stamps please*) Date/TIme

_____

Print Name

( ) _____ ( ) _____

Phone Fax

TELEPHONE ORDER READ BACK

_____

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salemhealth.org

☐ **Salem Hospital Anticoagulation Clinic**
Fax this referral order form to 503-814-1776
Questions and appointments call 503-814-1700

☐ **West Valley Anticoagulation Clinic**
Fax this referral order form to 503-917-2033
Questions and appointments call 503-917-2013

DSC 432299 (2/20)