Please send Completed Form to Anticoagulant Department
TEL - 01384 456111 (EXT 2380/2441)
FAX - 01384 244458 (INTERNAL 2258)

The Dudley Group NHS
NHS Foundation Trust

Surname:	Forename:	Date of birth:
Unit No.	NHS no:	
Address:	Consultant:	**Ambulance required:** Yes/No (delete)
	Tel no.	
GP:	GP Practice:	

Diagnosis and Indication for Anticoagulation:
(If VTE provoked or unprovoked) _____

Preferred method of Anticoagulation:
(Please tick)

O Warfarin (3mg as per hospital policy)
O Rivaroxaban (anti-Xa inhibitor, Xarelto)
(Consultant or GP referral ONLY for non-valvular AF)
O Other - Please state type of anticoagulant and why

_____

Duration of anticoagulation: _____

For Warfarin, please state target INR range: _____

Baseline bloods within 1 month of referral

Hb	_____ Date	_____	**eGFR**	_____ Date	_____
Plts	_____ Date	_____	**ALT**	_____ Date	_____
MCV	_____ Date	_____	**INR**	_____ Date	_____
			PTT Ratio	_____ Date	_____

If already on Warfarin, indications for switching to Novel Anticoagulant (NOAC):

A. Laboratory/poor INR Control (please tick)

1 INR >10 O
2 INRs >8 O
3 INRs >5 in 6 months O

B. Clinical: (please tick)

i) Polypharmacy O
ii) Bleeding event on Warfarin O
iii) Thrombotic event on Warfarin O
iv) Allergy intolerance to Warfarin O

NB: The NOACs are dose reduced if eGFR <50 and are NOT recommended if eGFR <30

C. Patient Preference: O

(Please note for this indication the patient must be informed that there is limited benefit and potential risk of converting to a NOAC in the setting of stable INRs)

Please list other medications: State 'none' if this is the case:

_____

_____

_____

NB: If the patient is on Aspirin/Clopidogrel/Dipyridamole should this/these be continued?
Yes/ No (please delete as appropriate)

Consultant: (or GP if Community-referral) _____

Signature: _____

Date: _____