

ARRMC Coumadin Clinic
2868 Creekside Circle, Medford, OR 97504
Phone 541-789-6385 * Fax 541-789-6388

Hours of Operation: Monday-Friday, 7:00 A.M. – 5:30 P.M.

COUMADIN MANAGEMENT SERVICE REFERRAL ORDER FORM

Orders for: _____ (patient name)

Date of Birth: _____

Please manage oral Coumadin therapy, educate, monitor, adjust dose, and record all interventions according to established RRMCC Coumadin Clinic protocol developed using current ACCP recommended guidelines.

Patient Current Uses (check one and detail dosage information):

- Coumadin Dosage _____
 Warfarin Dosage _____

The indication for warfarin therapy is:

- A fib Paroxysmal Persistent Chronic Unspecified
 Atrial flutter Typical Atypical
 DVT: Right Left Bilateral
 Mechanical heart valve Aortic Mitral _____
 PE
Chronicity Acute Chronic Unspecified
Add'l Without acute cor pulmonale With acute cor pulmonale
Add'l Septic Saddle Other

Other (specify) _____ Diagnosis code _____

Duration of therapy:

- Lifelong
 _____ months, until _____

Goal range for INR:

- 2.0 – 3.0
 2.5 – 3.5

Date ____ / ____ / ____ Time _____

Clinician (signature)

Clinician (printed name)