Anticoagulation Clinic

Procedure Order Form

PATIENT INFORMATION

Date: _____ / _____ / _____

Last Name: ______________ **First Name:** ______________ **MI:** _____ **Date of Birth:** ________

Procedure/Surgery: ______________________ **on** ____________ (Date) **@** ____________ (Time)

Ordering Practitioner: ______________________ **Surgeon:** ______________________

Reason for anticoagulation: ______________________

It is the physician's responsibility to confer with other physician if needed in order to obtain answers

WEST VALLEY HOSPITAL ANTICOAGULATION CLINIC MUST HAVE A VALID COMPLETE ORDER.

SECTION 1 — PLEASE MARK EACH QUESTION

What is the INR goal the day prior to procedure ____________ (*ie: 1.5 or less*)

Will patient need to go off their warfarin for this procedure? ☐ Yes ☐ No If yes, please complete section 2.

SECTION 2 — PLEASE MARK APPROPRIATE ANSWER

Bridge per West Valley Hospital ACC procedure protocol, **PRE and POST Procedure** ☐ Yes ☐ No
If no, please complete section 3. *(includes lab order for creatinine as needed)*

West Valley Hospital ACC will stop warfarin on the appropriate day in order that INR goal can be obtained. If you prefer a specific day for patient to take last dose of warfarin, please indicate ______________________

SECTION 3 – SPECIAL POST PROCEDURE INSTRUCTIONS

Resume low molecular weight heparin or fondaparinux on ____________ (*date*)

Resume warfarin on ____________ (*date*)

_______ Normal daily dose of warfarin X 3 days
_______ Normal daily dose of warfarin X 5 days
_______ Normal daily dose of warfarin X 7 days

Then resume normal weekly dose and dose per SHACC established protocol. Once INR is therapeutic, SHACC will resume pre-procedural weekly warfarin dose.

OR

_______ Double Average Daily Dose x 2 days, then resume pre-procedural weekly dose and adjust per post procedure protocol.

______________________ ____________
MD Signature (no signature stamps please) Date/Time

____
Print Name

Phone: (_____) ____________ Fax: (_____) ____________

TELEPHONE ORDER/READ BACK

RN Signature: ______________________

Physician Signature: ______________________

Date/Time: ______________________

West Valley Hospital
Fax this referral order to 503-917-2033
Questions and appointments call 503-917-2013

DSC 436368 (9/16)