

**GP REFERRAL FOR WARFARIN MONITORING BY UHBRISTOL ANTICOAGULANT MONITORING SERVICE**

**Patient details (or affix an addressograph label)**

|  |
| --- |
| Surname: …………………………………………….. NHS No: …………………………………………….Forename(s): ………………………………………………. Sex: M / FAddress: ………………………………………………………………………………………………………..……………………………………………………………………………………………………………………Postcode: …………………………………………… DOB: ……../……../……..Daytime Tel No: …………………………………… Mobile No: ……………………………..... |

GP Name, Address and Contact No: ………………………………………………………………………..

……………………………………………………………………………………………..……………………..

**Details of Warfarin therapy**

|  |  |
| --- | --- |
| Indication for anticoagulation: |  |
| Therapeutic range for INR: |  | Proposed duration of treatment: |  |
| **Special Needs - please circle if applies and give any relevant details:**Manual dexterity / Visual / Auditory / Language/ Learning difficulties/ Cognitive impairment / Speech / Compliance aidIf we need to contact a carer about warfarin dosing please give their name and contact number. Has the patient given consent for us to contact carer? **Yes / No** |

|  |
| --- |
| Has a DOAC been considered for this patient? **Yes / No**Details: |

**Please tick which service you require**

[ ]  Warfarin to be initiated and monitored by UHBristol OR

[ ]  Warfarin has already been started and the patient needs monitoring. Complete the table below.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date commenced: |  | Commenced by: |  | Date of last INR: |  |
| Result of last INR: |  | Warfarin dose: |  | Date of next INR test |  |

**Is the patient currently on subcutaneous LMWH?** Yes [ ]  No [ ]  If yes complete below

|  |  |
| --- | --- |
| Dose and duration of LMWH: |  |

Drs Name: …………………………… Drs Signature: …………………… Date of referral: ……………

**On receipt of this form the anticoagulant pharmacist will make a warfarin clinic appointment for the patient if necessary**

**EMAIL COMPLETED FORM AND A LIST OF CURRENT MEDICINES AND MEDICAL PROBLEMS TO warfarin.helpline@uhbw.nhs.uk**

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