EASTERN MAINE MEDICAL CENTER

Anticoagulation Clinic

915 Union Street, Suite 4, Bangor, Maine 04401

207.973.9970 / Fax 207.973.9971

Clinic Attending: William Breen, MD

REFERRAL FORM

Patient Identification

MRN# ______________________ Referral Date ____________________

Patient Name ______________________ Patient Home Phone # ______________________

Patient D.O.B. ______________________ Patient Cell # ______________________

Patient Mailing Address ____

Referring Practitioner ______________________ Practitioner Phone # ______________________

Practitioner Access # __________ Fax # __________

Primary Practitioner ______________________ Primary # ______________________

Practitioner Access # __________ Fax # __________

REASON FOR ANTICOAGULATION THERAPY AND DURATION

(Recommended by the ACCP)

(circle please)

Atrial Fib. . . . . 2.0 - 3.0

CVA . . . . 2.0 - 3.0

DVT . . . . 2.0 - 3.0

PE. . . . . 2.0 - 3.0

TIA. . . . . 2.0 - 3.0

Mechanical Heart Valve . . . . . . ________

Joint Replacement . . . . ________

Antiphospholipid Syndrome . . . ________

Other: ________________

____

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____

Lifetime Therapy (circle) Yes No ______________________________

Limited Therapy – end date: ____ Other: ______________________________

Current Anticoagulation Med(s) & Current Dose(s): ______________________________

____

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Last INR: Date ______________ Result ______________________________

CURRENT MEDS AND DOSAGES (Include OTC and Herbals) print and fax a summary

Practitioner Signature: ______________________ Printed Name: ______________________

Date: ________________ Time: ________________

Fax Form To: 207-973-9971

Registration Information: 1st appointment with ACC: ______________________ **Series patient:** ☐ **Yes** ☐ **No**

100002005

(1/10/18)