Warfarin Management Referral Form
Medica Pharmacy
1210 Erie St E.
Tel: 519-255-7777
Fax: 519- 255-7778

Patient Demographics

Patient Name:______________________________
__M__F : DOB (dd/mm/yy)
____
HCN:________________________________VC____
_
Address:____________________________________
_
Phone#____________________________________
_

Family MD:________________________________
Allergies:__________________________________

For Patients Who Require a Caregiver:
Care giver's name:____________________________________

Relationship to patient:
____

Phone#____

Reason for Referral	
Indication Eg . Afib, DVT, PE, etc **if mechanical valve present please specify type	
Target INR	
	For subtherapeutic INRs bridge with LMWH? ☐ YES or ☐ NO Bridge if INR is less than _______.
Duration	
Additional notes:	

Referring Physician

Name ____________________________________ Phone#______________________________
ID # ____________________________________
Signature ____________________________________