North Bay Regional Health Centre

Anticoagulation Clinic
Referral sheet

Name:

DOB:

HCN:

Phone:

Alternate phone:

J#:

Start date: ____________________________ Stop date: _______________________________

Allergies____

Reason for oral anticoagulant treatment: (Desired target range: ______________)

Warfarin (Coumadin) tablet strength: ________________ Daily dose: __________

INR frequency: ____________________ Last INR: ____________ Pharmacy: _____________

Current medication and dosage: (*please include herbals and non-prescriptions)*

☐ Home medication attached ☐ List continued on back of form

Other relevant clinical information:

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Date:________________________ Referring physician:_________________________________

Print name: _______________________________________

Please fax this form to the Anticoagulation Clinic – 705- 495-8137