



Patient's name:

Patient's DOB:

Patient's NHS No:

**REFERRAL TO ANTICOAGULATION CLINIC**

 **0208 934 2041 / 2053 / 2303 Administration Office**  
 **0208 934 2038 / 2041 Clinical Nurse Specialist**  
**Fax: 0208 934 3245**  
**Email: [khn-tr.anti-coagulationservicereferrals@nhs.net](mailto:khn-tr.anti-coagulationservicereferrals@nhs.net)**

The details given in this referral form are used to calculate a safe dose of anticoagulant for each patient. It is therefore essential that **all** sections of this form are completed. The anticoagulant clinic will not accept patients for anticoagulation unless all details requested below are supplied in full. RESPONSIBILITY FOR ANTICOAGULATION rests with the referring team until such time as the patient has been seen in the anticoagulant clinic.

**PATIENT'S DEMOGRAPHIC INFORMATION**

<b>Patient Surname:</b>	Mr Mrs Miss	<b>Hospital No:</b> ----- <b>NHS Number:</b>
<b>Forenames:</b>	Ms Dr	Date of Admission:
<b>Address:</b>		Ward: <b>HOSPITAL:</b>
Post code:		Consultant:
Fixed Line Tel No: Mobile No: Email:	<b>Date of birth:</b> (dd/mm/yyyy)	Clinic appointment date <i>(if applicable)</i> :
<b>GP Name:</b>	<b>Next Of Kin Details</b>	
GP Address:	Name: Address:	
Post code:	Telephone number:	
GP Tel Number:	Email address:	
GP Signature:	<b>Transport required: YES / NO</b>	
Date:	NB. Transport for the first appointment <b>MUST</b> be arranged by the Ward.	

Living our values everyday



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**PATIENT'S CLINICAL INFORMATION**

<b>Recent Investigation results:</b> Urea, creatinine and eGFR FBC Weight: kg	
<b>Medical conditions (to be drawn from Past Medical Conditions)</b>	
<b>Present Medication, dose and frequency:</b> (Drawn from discharge list or outpatient list if possible)	Aspirin Y/N Clopidogrel Y/N
<b>Drug Allergies</b>	D/N's required Y/N Transport required Y/N Interpreter required Y/N

**If the patient has already started warfarin** please complete table below showing last 3 INR values.

Date	Warfarin dose	INR	

INDICATION FOR ORAL ANTICOAGULATION – ✓ Tick that which applies			
CONDITION	TARGET INR (RANGE)	DURATION	✓
<b>ATRIAL FIBRILLATION</b> ATRIAL FIBRILLATION ATRIAL FIBRILLATION <u>Please complete embolic risk assessment below</u>	2.5 (2.0 – 3.0) 2.5 (2.0 – 3.0)	6 WEEKS PRE & POST CARDIOVERSION LONG TERM	
PULMONARY EMBOLUS	2.5 (2.0 – 3.0)	6 MONTHS	
PROXIMAL DVT (INCLUDES POPLITEAL)	2.5 (2.0 – 3.0)	6 MONTHS	
CALF DVT, POST-OP & NO OTHER RISK FACTORS	2.5 (2.0 – 3.0)	6 MONTHS	
CALF DVT, NON-SURGICAL	2.5 (2.0 – 3.0)	3 MONTHS	
RECURRENT DVT	2.5 (2.0 – 3.0)	LONG TERM	
RECURRENT PE	2.5 (2.0 – 3.0)	LONG TERM	
RECURRENT DVT WITH INR 2-3	3.5 (3.0 – 4.0)	LONG TERM	
MURAL THROMBUS OR AKINETIC SEGMENT	2.5 (2.0 – 3.0)		
<b>MECHANICAL HEART VALVES</b> MECHANICAL AVR (BILEAFLET OR TILTING DISC) MECHANICAL MVR ± AVR (BILEAFLET/TILTING VALVE) THROMBO-EMBOLI IN SPITE OF THERAPEUTIC INR NB SOME PATIENTS WITH MECHANICAL VALVES MAY NEED HIGHER INRS	2.5 (2.0 – 3.0) 3.0 (2.5 – 3.5) 3.5 (3.0 – 4.0)	LONG TERM LONG TERM LONG TERM	
OTHER INDICATIONS	SPECIFY		

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- Patients with metastatic malignancy may require an individual anticoagulation plan  
**If patient has atrial fibrillation, it is essential that THE RISK ASSESSMENT is completed**

**THE CLINICAL RISK ASSESSMENT FOR PATIENTS WITH NON-VALVULAR ATRIAL FIBRILLATION**

**Risk assessment 1: CHA<sub>2</sub>DS<sub>2</sub>-VASC scoring systems for non-valvular atrial fibrillation**

The CHA<sub>2</sub>DS<sub>2</sub>-VASC score is better than the older CHADS<sub>2</sub> score at identifying those patients who are truly at 'low risk' from AF (i.e. CHA<sub>2</sub>DS<sub>2</sub>-VASC = 0, which is essentially patients <65years with lone AF and no additional risk factors). For these patients, **no antithrombotic** therapy is generally the preferred option. Patients with one or more risk factors (i.e. CHA<sub>2</sub>DS<sub>2</sub>-VASC score of ≥ 1, but excluding female gender, should be considered for anticoagulation.

	Risk Factor	Score
<b>C</b>	Congestive heart failure / LV dysfunction ≤ 40%	1
<b>H</b>	Hypertension	1
<b>A<sub>2</sub></b>	Age ≥ 75 years	2
<b>D</b>	Diabetes Mellitus	1
<b>S<sub>2</sub></b>	Stroke / TIA/ Systemic embolism	2
<b>V</b>	Vascular disease (e.g. prior MI, peripheral artery disease, aortic plaque)	1
<b>A</b>	Age 65-74 years	1
<b>Sc</b>	Sex category (i.e. female)	1
<b>Maximum score</b>		9
<b>PATIENT SCORE</b>		

CHA <sub>2</sub> DS <sub>2</sub> -VASC score	Adjusted stroke rate (%/year)
0	0%
1	1.3%
2	2.2%
3	3.2%
4	4.0%

**Risk assessment 2: HAS-BLED**

The risk of bleeding should be assessed before starting anticoagulation and at least annually (with the annual review of AF). The HAS-BLED scoring system has been validated as a practical tool that can be used to assess the bleeding risk in patients with AF.

acronym	Risk Factor	Score
<b>H</b>	Hypertension (systolic BP > 160mmHg)	1
<b>A</b>	Abnormal renal and liver function (1 point each) <ul style="list-style-type: none"> <li>Abnormal renal function: chronic dialysis, renal transplantation or serum Cr &gt; 200µmol/L</li> <li>Abnormal liver function: chronic hepatic disease (e.g. cirrhosis) or biochemical evidence of significant hepatic derangement (e.g. bilirubin &gt; 2 x upper limit of normal in association with AST/ALT/ALP &gt; 3x upper limit of normal)</li> </ul>	1 or 2
<b>S</b>	Stroke	1
<b>B</b>	Bleeding (previous bleeding history and/or predisposition to bleeding e.g. bleeding diathesis, anaemia etc.)	1
<b>L</b>	Labile INR's (unstable/high INR's or poor time in therapeutic range e.g. < 60%)	1
<b>E</b>	Elderly (e.g. age > 65years)	1
<b>D</b>	Drugs or alcohol (1 point each) – concomitant use of e.g. antiplatelets, NSAIDs, or alcohol abuse	1 or 2
<b>Maximum score</b>		9
<b>PATIENT SCORE</b>		

HAS-BLED score	Major bleeds per 100 pt years
0	1.13
1	1.02
2	1.88
3	3.74
4	8.70

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A **HAS-BLED score of  $\geq 3$**  indicates that the patient is at **high risk of bleeding** and some caution and regular review of the patient is required following the initiation of antithrombotic therapy. Efforts should be made to correct potentially reversible risk factors for bleeding. A high HAS-BLED score per se, should not be used to exclude patients from anticoagulant therapy. *(Note that for a given HAS-BLED score, the ICH (and major bleeding) rate in patients taking aspirin, was similar to that seen with patients taking warfarin. Therefore compared to warfarin, aspirin is not only a less effective antithrombotic agent for stroke prevention, but carries a similar risk of bleeding.)*

**If you decide a NOAC should be prescribed** for the patient please identify below the reason for the choice below: