Anticoagulation Clinic

Procedure Order Form

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Date: ____ /____ /____

Last Name: _____ **First Name:** _____ **MI:** ____ **Date of Birth:** _____

Procedure/Surgery: _____ **on** _____ (Date) **@** _____ (Time)

Ordering Practitioner: _____ **Surgeon:** _____

Reason for anticoagulation: _____

It is the physician's responsibility to confer with other physician if needed in order to obtain answers
SALEM HOSPITAL ANTICOAGULATION CLINIC MUST HAVE A VALID COMPLETE ORDER.

SECTION 1 — PLEASE MARK EACH QUESTION

What is the INR goal the day prior to procedure _____ (*ie: 1.5 or less*)

Will patient need to go off their warfarin for this procedure? ☐ Yes ☐ No If yes, please complete section 2.

SECTION 2 — PLEASE MARK APPROPRIATE ANSWER

Bridge per Salem Hospital ACC procedure protocol, **PRE and POST Procedure** ☐ Yes ☐ No If no, please complete section 3. *(includes lab order for creatinine as needed)*

Salem Hospital ACC will stop warfarin on the appropriate day in order that INR goal can be obtained. If you prefer a specific day for patient to take last dose of warfarin, please indicate _____

SECTION 3 – SPECIAL POST PROCEDURE INSTRUCTIONS

Resume low molecular weight heparin or fondaparinux on _____ (*date*)

Resume warfarin on _____ (*date*)

_____ Normal daily dose of warfarin X 3 days

_____ Normal daily dose of warfarin X 5 days

_____ Normal daily dose of warfarin X 7 days

Then resume normal weekly dose and dose per SHACC established protocol. Once INR is therapeutic, SHACC will resume pre-procedural weekly warfarin dose.

OR

_____ Double Average Daily Dose x 2 days, then resume pre-procedural weekly dose and adjust per post procedure protocol.

_____ _____
MD Signature (no signature stamps please) Date/Time

_____
Print Name

Phone: (____) _____ Fax: (____) _____

TELEPHONE ORDER/READ BACK

RN Signature: _____

Physician Signature: _____

Date/Time: _____