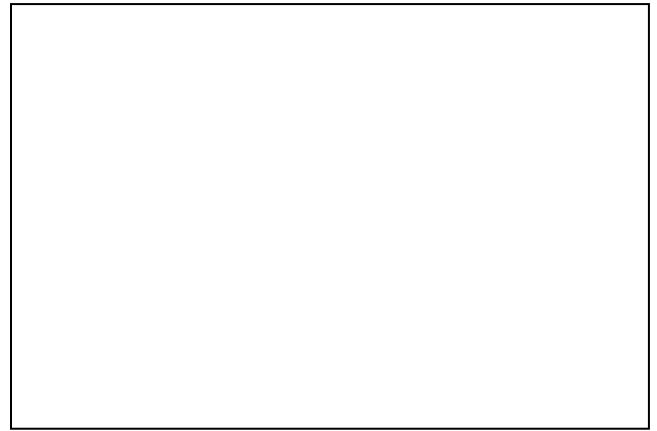


# Atrial Fibrillation Oral Anticoagulation Clinic at University Hospital



## Referral Form

Date of referral: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Health Card or PIN Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Referring Physician Contact Phone #: \_\_\_\_\_

### Reason for Referral:

- Atrial Fibrillation – requiring warfarin, please **supervise anticoagulation**
- Atrial Fibrillation – assess **need for anticoagulation** and **supervise anticoagulation**
- Atrial Fibrillation – **supervise rate/rhythm** control and **supervise anticoagulation**

### Comorbidities (if known):

- Age > 75
- History of Hypertension
- Diabetes Mellitus
- History of Ischemic Stroke
- LV systolic dysfunction - **attach recent**

#### echocardiogram or complete following:

- Estimated Ejection Fraction (if known)  
\_\_\_\_\_
- Date of echocardiogram (if known)  
\_\_\_\_\_
- Location of echocardiogram (if known)  
\_\_\_\_\_

- Valvular Heart Disease – details:  
\_\_\_\_\_

- History of GI bleed:  
\_\_\_\_\_
- History of intracranial hemorrhage:  
\_\_\_\_\_
- Dementia:  
\_\_\_\_\_
- History of falls:  
\_\_\_\_\_
- Currently pregnant/considering pregnancy:  
\_\_\_\_\_

**\* Please keep a copy of this referral form on file in your work area for future use.**

**\*\*Please attach relevant information regarding medical history/medications or pertinent investigations.**