



DIAGNOSTIC COAGULATION CENTER
Outpatient Consultation Referral Form
Phone: (603) 650-6763 Fax: (603) 650-6786

Referring Provider:	Patient Name: Name of Guardian/Parent if <18yo:
Office Phone:	DOB:
Office Fax:	DHMC-MR# (if known):
Please Note: A secretary from the Diagnostic Coagulation Clinic will contact your patient directly to schedule an outpatient appointment.	Patient's Daytime Phone number:
Urgent (Within 10 days) Please call (603) 650-6763. Ask to speak with the Clinical Nurse Specialist.	Stable (Next available) Please fax this form with all pertinent information.
Reason for consultation: <input type="checkbox"/> Hemophilia <input type="checkbox"/> Bleeding <input type="checkbox"/> Thrombosis <input type="checkbox"/> Other	
<u>Specific question(s) to be answered?</u>	

Please indicate if records are available in Dartmouth-Hitchcock clinical system: CIS North CIS South

OR

Please fax copies of the following reports (if available) with this form to **(603) 650-6786**:

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| <input type="checkbox"/> Patient demographics (required) | <input type="checkbox"/> Discharge summaries within 5 years |
| <input type="checkbox"/> Medication list (required) | <input type="checkbox"/> Surgical/Trauma Notes |
| <input type="checkbox"/> Coagulation office notes (required) | <input type="checkbox"/> MRI / CT Scan Reports |
| <input type="checkbox"/> Coagulation blood work (if done)* | <input type="checkbox"/> Other pertinent studies related to bleeding or thrombosis |

**We do not recommend performing specialized coagulation blood testing prior to the appointment. However, if tests have been done previously, e.g., factor 8, vWF, protein C & S, factor V Leiden etc., please send us the results. Only recent INR values are necessary*

Please note: Incomplete or illegible information on this form may delay scheduling your patient for a coagulation consultation. Please let your patient know that if he/she does not hear from us within 5 days to call **(603) 650-6763** for immediate assistance.

Thank you for referring your patient to the DHMC Diagnostic Coagulation Clinic.

DHMC USE ONLY:

- | | |
|--|--|
| <input type="checkbox"/> Appt scheduled (date) NPW _____ EPF _____ | <input type="checkbox"/> Pt initially notified of NPW (date) _____ |
| <input type="checkbox"/> Introduction letter/questionnaire sent (date) _____ | <input type="checkbox"/> Reminder call for NPW made (date) _____ |