

Appendix H
Northwest Anticoagulation Clinic (NWAC)
Collaborative Care and Management Protocol Agreement
Physician Signature Page

Referring Physician- Responsible for the overall care of the patient. The referring physician will determine the indication for anticoagulation, desired range of the INR and duration of therapy. He/she will be responsible for communication with the clinical staff any special considerations for the patient. The referring physician will be contacted by the clinical staff with any medical concerns that need immediate attention. If referring physician cannot be contacted the clinical staff will address the issue with the medical director. The referring physician will be the collaborative physician of record granting prescriptive authority to the clinical staff as it pertains to only adjusting the warfarin dosage or tablet strength, holding doses, ordering of PT/INR, CBC, CMP. NWAC will consult with physician for bridge therapy (LMWH) for surgical procedures as deemed necessary for the monitoring of the patient's anticoagulation therapy.

Please Fax to (206) 368-3004

I, _____, agree with the terms of the NWAC Outpatient Anticoagulation Management Protocol. I understand my responsibilities as the referring physician. Prescriptive Authority will be granted for a period of two years.

Signature _____ Date _____

Please provide your contact information for patient related information:

Phone Number _____

Fax Number to send patient Anticoagulation Clinic notes: _____

Address _____

I, _____, do not wish to enter into this agreement with the Northwest Anticoagulation Clinic Service. I understand that the patients in which I am listed as the referring physician will be discharged back to my office for further anticoagulation management.

Signature _____ Date _____

Northwest Anticoagulation Service Pharmacist Statement

This protocol has been reviewed by all Pharmacists within the Anticoagulation Services and agree to adhere to the responsibilities outlined within this agreement and protocol.

_____ Date _____ Anticoagulation Service Coordinator

A signature log of the individual pharmacists will be housed with the physician signatures.

Please retain a copy of this form