Huntington Health **MEDICATION THERAPY MANAGEMENT (MTM) CLINIC – Physician Referral Form**

Phone: 626-397-5559 Fax: 626-397-2934 ***mtmclinic@huntingtonhealth.org***

Patient Name: _____ Date of Birth: _____

Home Phone Number: _____ Cell Number: _____

Past Medical History: _____

Complete all the areas under the service for which you are referring the patient:

ANTICOAGULATION MANAGEMENT

1. Indication: ☐ AFib ☐ DVT ☐ PE ☐ Mechanical AVR ☐ Mechanical MVR ☐ Tissue AVR ☐ Tissue MVR
☐ Other: _____

2. Duration of therapy: ☐ _____ months ☐ lifelong

→ **Warfarin**: INR range ☐ 2-3 ☐ 2.5 – 3.5 ☐ Other: _____ Reason: _____
Warfarin dose: _____ Last INR / Date: _____ / _____

3. Lovenox dose (if bridging with warfarin): _____
D/C Lovenox when INR ≥2 for 24 hrs? ☐ Yes ☐ Other instructions: _____
Restart Lovenox (if <3 months from VTE) when INR < _____ or ☐ do not restart because _____

→ **OR DOAC (Direct Oral Anticoagulant)**: ***education, monitoring of ADRs, drug interactions, SCr***
Name & Dose: _____ Latest SCr / Date: _____ /_____

CARDIOVASCULAR THERAPY MANAGEMENT (Select): ☐ Heart Failure ☐ Hypertension ☐ Dyslipidemia

Please fax a copy of the most recent relevant lab results.

Hypertension: BP Goal: < _____ (Pt last Wt: _____ BP: _____ Pulse: _____ Date: _____)
Intolerance to anti-hypertensive medications: _____

Dyslipidemia: LDL Goal: ☐ < 100 ☐ <55 ☐ < _____ ☐ Ordering Leqvio 284mg SQ initiation

Heart failure: ☐ HFrEF ☐ HFpEF NYHA Class: ☐ I ☐ II ☐ III ☐ IV Class (circle): A B C D
EF (%): _____ Date:_____ Salt/Fluid Restrictions: _____

DIABETES MEDICATION MANAGEMENT

A1C/FPG Goals: ☐ < 8%/140 mg/dL ☐ < 7%/120mg/dL
☐ Other: _____ Reason: _____

For new start insulin: D/C oral antidiabetic meds? ☐ Yes ☐ No ☐ Other instructions _____
Insulin Regimen: ☐ Once daily ☐ Multi-dose ☐ Intensive
Basal Name/Dose: _____
Bolus Name/Dose: _____

PHYSICIAN INFORMATION

Referring Physician Name: _____ Phone Number: _____

Referring Physician's Signature/Physician's Agent: _____ Date: _____

☐ I have contacted the **Monitoring Physician,** who accepts care after discharge. OR ☐ Check here if Monitoring & Referring doctors are the same

Monitoring Physician Name: _____ Phone Number: _____

Monitoring Physician's Signature/Physician's Agent: _____ Date: _____