Anticoagulation STOP Request (Sample)

Date:_____

To:_____ Fax:_____

Re:_____ DOB:_____

Please FAX your response to Dr. _____ Fax:_____

The above named patient has a scheduled procedure and is currently taking an anticoagulant prescribed by your office. In order to ensure patient safety, we would like to confirm that the patient can place their anticoagulant medication on hold for the procedure. Can he/she discontinue the anticoagulant _____ for a minimum of _____ days prior to the procedure?

- ☐ Yes, patient can discontinue taking the anticoagulant as noted above.
- ☐ No, patient cannot discontinue taking the anticoagulant.
- ☐ Other_____
  _____
  _____

We will provide detailed instructions about when to stop and restart the medication before/after the procedure.

Authorizing Physician:_____ Date:_____

Print Provider Name:_____