Appendix A-7b: Pharmacy Accepts Referral From Provider

[Insert Health System Atrial Fibrillation Medication Management Clinic]
Part of the [Insert Health System Atrial Fibrillation Center of Excellence (AF CoE)]

Patient Name:
Patient MRN:
DOB Age Gender:

Date:
Time:

Referral Reason: Asked to manage atrial fibrillation medication

Indication for Referral: Anticoagulation management and rate control

Resting HR Goal: ≤110 bpm

Current Atrial Fibrillation Regimen (if applicable): Diltiazem (CARDIZEM CD 120 mg daily and rivaroxaban (Xarelto) 20 mg daily with dinner meal.

CHA_2DS_2-VASc (2.2% risk of stroke per year)
Age (65–74 years) (1 point)
Female (1 point)

Duration of Therapy: Indefinite

Current Medications	
Medication	Sig
dilTIAZem (CARDIZEM CD) 120 MG 24 hr capsule	**120 mg, Oral, Daily**
rivaroxaban (XARELTO) 20 mg Tab	**20 mg, Oral, Daily with dinner**

Progress Note: This is a [insert age] y.o. female with a history of paroxysmal AF who was referred to [Health System AF CoE Clinic/Health System AMS] for rate control and anticoagulation management. PMH includes no known cardiac risk factors of hypertension, diabetes, dyslipidemia, or smoking. However, noted palpitations, predominantly with exertion over the last 2 years.

Patient is currently anticoagulated for stroke prevention with rivaroxaban (Xarelto) 20 mg daily. Rate control regimen includes diltiazem (Cardizem CD) 120 mg daily.

Spoke with patient via Zoom and went over the 6MWT instructions (see below) and patient received education on anticoagulation therapy. Patient verbalized that she already has a blood pressure monitor, but she doesn't have a pulse oximeter. I plan to have [Insert name] mail a pulse oximeter to patient. We plan to schedule her first 6MWT once she receives the pulse oximeter. She will take her blood pressure and send the readings along with the 6MWT results to Atrial Fibrillation Medication Management Clinic via the patient portal. I answered all her questions.

Atrial Fibrillation Medication Management Clinic

6-Minute Walk Test Instructions and Tracking Sheet
Instructions

- The goal of the 6-Minute Walk Test (6MWT) is to walk for 6 minutes. You are allowed to slow down, stop, and rest as necessary. If you need to rest, try to start walking again as soon as you are able
- Ideally, aim for a level of moderate activity. This will be different for each patient but should challenge you to push past a comfortable activity level

Activity Level	Descriptive Measure
Sedentary	Activities that have little additional movement
Light	An activity that does not cause a noticeable change in breathing. Feels easy
Moderate	An activity that is challenging but able to be conducted while maintaining a conversation uninterrupted. Feels like fast walking
Vigorous	An activity in which a conversation generally cannot be maintained uninterrupted. Feels like running

- Wear comfortable clothing and shoes
- Bring any walking aids (if you normally use them) such as walkers or canes
- It is ok to eat a small meal before your walk test
- Take all your usual medications
- Do not perform any vigorous exercise 2 hours prior to your 6MWT
- No warm-up is required
- Please fill out the table attached below for each 6MWT you complete

Measurements

- You will need to measure your heart rate (HR) and, if available, your oxygen saturation (SpO2) prior to your 6MWT
    - Prior to beginning your test, you should be resting comfortably for about 10 minutes
    - During this time when you are resting before your test, please measure your HR and SpO2
- 3 minutes into your 6MWT, please measure your HR and SpO2
- After you have completed your 6MWT, we will also need you to check your HR and SpO2 again, as well as document any symptoms you experienced during the test
    - For example: Did you need to take a break at any point during the 6MWT?
    - What symptoms did you experience?
        - Chest pain, shortness of breath, fatigue, dizziness

6-Minute Walk Test (6MWT) Questionnaire

Date/Time:	
What was your Heart Rate before the 6MWT (at 0 minutes)?	BPM
If available, what was your Oxygen Saturation before the test?	%
What was your Heart Rate at 3 minutes?	BPM
If available, what was your Oxygen Saturation at 3 minutes?	%

What was your Heart Rate after the 6MWT (at 6 minutes)?	BPM
If available, what was your Oxygen Saturation after the 6MWT?	%
Did you have any symptoms during the 6MWT such as chest pain, shortness of breath, fatigue, dizziness?	Yes or No
If you did experience symptoms during your test, please note what you experienced.	Symptoms, if applicable:
How many times (if any) did you have to take a break during your 6MWT?	Number of breaks taken:
Any additional information you would like your clinician to know	

Safety Reminders

- Watch for symptoms of chest pain and/or shortness of breath unrelated to poor physical health
- Stop the 6MWT and call your doctor or Atrial Fibrillation Medication Management Clinic right away if any of the following occurs
    - SpO2 <85%
    - Intolerable shortness of breath
    - Lack of coordination and/or mental confusion
    - Leg cramps or extreme leg muscle fatigue
    - Staggering
    - Extreme fatigue
    - Excessive sweating
    - Lightheadedness and/or dizziness
    - Pale or ashen appearance
- If you plan to perform the 6MWT during our off hours and you experience any of the above symptoms, please report to the nearest emergency department and/or page an Atrial Fibrillation Center of Excellence doctor for consideration of emergency care

Adapted from the following references:

1. ATS Committee on Proficiency Standards for Clinical Pulmonary Function Laboratories. ATS statement: guidelines for the six-minute walk test. *Am J Respir Crit Care Med*. 2002;166(1):111-117. doi:10.1164/ajrccm.166.1.at1102
2. American Association of Heart Failure Nurses. Six Minute Walk Test Instructions and Tracking Sheet. Accessed January 23, 2024. https://cdn.ymaws.com/www.aahfn.org/resource/resmgr/docs/awareness/2017_HF_Week/6_Minute_Walk_Test_Instructi.pdf

Virtual Visit Attestation
Modality: video
Provider Location: home / other
Patient Location: home
Patient State:

Yours sincerely,

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Advanced Practice Clinical Pharmacist

Referral accepted documentation:

Referring attending MD
(The referral for atrial fibrillation medication management was made to [Dr. X] who referred the patient to be managed by a pharmacist in the Chronic Atrial Fibrillation Medication Management Clinic).

Consult Received: The [Insert Health System Atrial Fibrillation Medication Management Clinic] will manage the atrial fibrillation medication therapy for [patient name] based on the above indication. All recommendations made under the Atrial Fibrillation Medication Management Clinic will be documented in the EHR including, but not limited to, initiation, modification, or discontinuation of a patient's medications and tests ordered. For daily progress notes and daily direct patient care notes, please contact the clinic directly for access.

Consent: I have reviewed the [Insert Health System Atrial Fibrillation Medication Management Clinic] Patient Agreement Form with the patient. I have discussed with the patient their condition as well as the risks, benefits, and alternatives associated with their treatment and with no treatment. I have given the patient and family the opportunity to ask questions, and, at this time, all of their questions have been answered to their satisfaction. The patient has given consent to have their condition managed within this collaborative practice.

New Patient Education Completed: Patient/family member has been educated and verbalized understanding of the indication for atrial fibrillation medication, the importance of adherence to medication dose/schedule, follow-up with the clinician for laboratory testing to assess clinical improvement and toxicity, blood pressure measurements and heart rate measurements per clinician instruction, potential medication interactions, and cardiovascular risks associated with their disease state.

For any questions or concerns, please feel free to contact the [Insert Health System Atrial Fibrillation Medication Management Clinic] service via email [Insert email address]. For urgent issues please page [Insert name] or call [Insert phone number].

Please NOTE: All referrals will expire annually OR upon completion of the indicated duration of therapy, whichever comes first. Our service will contact you at this time with a renewal request and your patient's treatment summary.

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Advanced Practice Clinical Pharmacist
Referring Prescriber
[Insert Health System Anticoagulation Management Service (AMS)]

***Patient Name**:*
***Patient MRN**:*
DOB Age Gender:

Date:

Time:

Referral Reason: Asked to manage anticoagulation therapy

Indication for Anticoagulation:

Anticoagulant Regimen:

Target INR (if applicable): N/A

Duration of Therapy:

Referring attending MD (The referral for anticoagulation management was made to Dr. [Insert name] who referred the patient to be managed by a pharmacist in the Anticoagulation Management Service): Dr. [Insert name]

Consult Received: The [Insert Health System Atrial Fibrillation Medication Management Clinic] will manage the anticoagulation for [Insert patient name] based on the above indication. For daily progress notes and dosing instructions, please click on the AMS indicator in the patient header in the EHR and an anticoagulation report will display on the right side of the screen.

Consent: I have reviewed the AMS Patient Agreement Form with the patient. I have discussed with the patient their condition as well as the risks, benefits, and alternatives associated with their treatment and with no treatment. I have given the patient and family the opportunity to ask questions and, at this time, all of their questions have been answered to their satisfaction. The patient has given consent to have their condition managed within this collaborative practice.

New Patient Education Completed: Patient/family member has been educated and verbalized understanding of the indication for anticoagulation, the importance of adherence to medication dose/schedule and follow-up with AMS clinician and laboratory testing per clinician instruction, potential food/medication interactions, clotting risks associated with their disease state, and bleeding risks associated with anticoagulants.

For any questions or concerns, please feel free to contact the AMS service via email [Insert email address] or via an EHR message to the [Insert Health System Anticoagulation Clinic]. For urgent issues please page [Insert name] or call [Insert phone number].

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Advanced Practice Clinical Pharmacist
Prescriber