



# WARFARIN PATIENT RECORD SHEET

ATTACH  
PATIENT INFORMATION  
LABEL HERE

## PATIENT INFORMATION

<p>SURNAME OF PATIENT _____</p> <p>Indications:    <input type="checkbox"/> atrial fibrillation        <input type="checkbox"/> DVT/PE                          <input type="checkbox"/> thrombophilia                <input type="checkbox"/> prosthetic heart valve                          <input type="checkbox"/> intracardiac thrombus    <input type="checkbox"/> Other: →</p> <p>Target INR Range: <input type="checkbox"/> 2.0 – 3.0    <input type="checkbox"/> 2.5 – 3.5    <input type="checkbox"/> Other: →</p> <p>Duration:        <input type="checkbox"/> 3 mos    <input type="checkbox"/> lifelong    <input type="checkbox"/> reassess when: →</p> <p>Oral Anticoagulant: <input type="checkbox"/> Coumadin    <input type="checkbox"/> Other: →</p>	<p>FIRST NAME (INITIALS) _____</p> <p>PHN _____</p> <p>Please complete and indicate 1<sup>st</sup> and 2<sup>nd</sup> preference for contact</p> <p>___ Work Phone: (    ) _____</p> <p>___ Home Phone: (    ) _____</p> <p>___ Cell: (    ) _____</p> <p>___ Pager: (    ) _____</p> <p>___ Fax: (    ) _____</p> <p>___ Email: _____</p>
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- Tablet Strengths:     1 - pink                       2.5 - green                       4 - blue                       6 - teal                       10 - white  
                                2 - lavender                       3 - tan                       5 - peach                       7 - yellow

## OTHER INFORMATION

NAME OF PRIMARY PHYSICIAN _____	TELEPHONE NUMBER _____	FAX _____
NAME OF SPECIALIST _____	TELEPHONE NUMBER _____	FAX _____
NAME OF SPECIALIST _____	TELEPHONE NUMBER _____	FAX _____
INR RESULTS ALSO COPIED TO: _____	DATE _____	FAX _____

LAB	PHARMACY	OTHER	Specimen Date	HB if done	PLTS if done	INR Result	Dosage Instruction	Weekly mg	Next INR	MD Initials	Date/Status of Patient Notification	Notifier Initials
											D: S:	
											D: S:	
											D: S:	
											D: S:	
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