Patient Name______________________________________Date of Birth_______________

Is another provider managing your Coumadin/Warfarin at another clinic? ☐ Yes ☐ No
If yes, whom? Name_________________________________
Fax#: __________________
If you answered yes to the above question, no need to complete form.

Managing Coumadin/Warfarin

To be Completed by Patient:	Yes	No	Unsure
Since your last INR visit			
1. Is Coumadin/Warfarin a new medication for you within the last 2 weeks?			
2. Have you stopped your Coumadin /Warfarin for more than 2 days, or just restarted?			
3. Have you been preparing for a procedure (colonoscopy, cardioversion, surgery, dental work, epidural injections, etc.)?			
4. Are you currently on an injectable anti-coagulant (Lovenox, Heparin, etc.)?			

Since your last INR have you?

Missed Dose?	☐ Yes	☐ No
Extra Doses?	☐ Yes	☐ No
Medication Changes?	☐ Yes	☐ No
Bleeding Gums?	☐ Yes	☐ No
Nose Bleeds?	☐ Yes	☐ No
Antibiotic Use?	☐ Yes	☐ No
Over The Counter/Herbal Medications?	☐ Yes	☐ No

Diet Changes?	☐ Yes	☐ No
Blood in urine?	☐ Yes	☐ No
Blood in Stool?	☐ Yes	☐ No
Dental/Other Procedures?	☐ Yes	☐ No
Hospitalization?	☐ Yes	☐ No
Any Unusual Bruising?	☐ Yes	☐ No
Alcohol Usage Changes?	☐ Yes	☐ No

Please list over the counter medications if known:

Please fill in your current Coumadin/Warfarin dose below for the last week						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
mg	mg	mg	mg	mg	mg	mg

What phone number can you be reached at **TODAY**?

7/31/15 kb

HC ANTICOAGULATION VISIT FORM 4459	Hutchinson HEALTH CLINIC	*Patient Label*