Warfarin

Indication: **Duration:** **Target INR/Range:**

Drug (Generic name)
Warfarin

Start date Route Freq

Monitoring Instructions
Dates on which INR to be measured

Verified by (signature)

Date

On Admission Medication Reconciliation

Existing warfarin patient? Yes ☐ No ☐

Dose on admission:

Has Own Warfarin Book? Yes ☐ No ☐

Got New Warfarin Book? Yes ☐ No ☐

Counselled by:

Signed: Date:

Long-term Monitoring by:

Warfarin Clinic ☐ GP ☐ Self ☐

Community Pharmacist ☐

Signed: Date:

Stop Date

Reason

Prescriber Sig

Date	INR	Dose	Prescriber Sig	Given by	Time

Continue at Discharge Yes ☐ No ☐ Initials