Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

Warfarin Care hospital discharge form

Please complete details below prior to patient discharge to ensure safe management.

(For patients who are already enrolled on the Warfarin Care programme only)

FAX TO: 07 3377 8461 or Email: warfarincaresupport@snp.com.au once complete

PATIENT NAME: _____ DOB: ____/____/____

HOSPITAL / WARD: _____ DATE OF ADMISSION: ____/____/____ DATE OF DISCHARGE: ____/____/____

ADMITTING CONSULTANT: _____

1. What was the patient's reason for admission? _____
2. Did the patient cease Warfarin? Y N
3. Did the patient have Vitamin K in hospital? Y N
4. What date did the patient recommence Warfarin? ____/____/____
5. Was the patient given Clexane in hospital? Y N
6. Does the patient have any new medication / antibiotics? _____

_____

7. Target range? _____

(NB Warfarin Care requires a target range of **one whole unit**)

What dose of warfarin was the patient given **whilst in hospital?**

Date	INR	Dose
/ /		
/ /		
/ /		
/ /		

Discharge dose given? _____

Please ensure the patient tests within the next three (3) days.

Completed by:

Name: _____ Signature: _____