Appendix 3. Office Anticoagulant Information and INR Flowsheet

Patient Name:_____**Date of Birth:** _____

Phone Number: _____

Name and contact phone number of caregiver: _____

Name and phone number of Pharmacy: _____

Indication for Anticoagulation:_____

Target INR: _____

Date	INR result	Medication Dose: (Note changes in dose, Coumadin tab size, etc.)	Next Lab Test (Date)	Patient Notified (provider initials)

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