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 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 and if so what date? _____
3. Did the patient have vitamin K in hospital? _____
4. What date did the patient recommence warfarin? _____
5. Was the patient given Clexane in hospital? _____
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 and on discharge?

Date	INR	Dose
/ /		
/ /		
/ /		
/ /		

Completed by:

Name: _____ Signature: _____

Thank you