Sullivan Nicolaides PATHOLOGY
Quality is in our DNA

Warfarin Care enrolment application form

APPLICATION FOR WARFARIN CARE ENROLMENT - FOR PRIVATE HOSPITALS, GENERAL PRACTITIONERS & PRIVATE SPECIALISTS. Fax to: 07 3377 8461 when completed.

Completion of all fields is mandatory; if the form is not completed the enrolment will be declined.

Submission of an application for enrolment does **not guarantee automatic acceptance** on our Warfarin Care programme;

Please refer to the website for our Eligibility Criteria and Billing Information (Clinicians > Requesting pathology > Warfarin Care)

Does the patient accept the Warfarin Care fee? (mandatory completion required, excluding Nursing Home patients) ☐ Yes ☐ No

Patient Signature: _____

Patient Name _____

DOB: ____/____/____ Sex: ☐ F ☐ M ☐ U

Address: _____

_____

Home Ph: _____ Mobile: _____

Carer/NOK Name: _____

Phone: _____

Referring Doctor (Specialists must include the patient's GP)

Name: _____

Suburb: _____ Ph: _____

General Practitioner

Name: _____

Suburb: _____ Ph: _____

Hospital: Recent Admission if Applicable

Hospital: _____

Ward: _____

Date of discharge: ____/____/____

Patient Authority

I hereby authorise Sullivan Nicolaides Pathology to obtain from my medical records, all clinical information relevant to my warfarin management.

Name: _____

Signature: _____ Date: ____/____/____

Completed by ☐ Patient ☐ Agent* _____

*If agent, please provide relationship to patient (e.g. carer, family member, doctor, nurse etc.)

Completed by

Name: _____

Position: _____

Date: ____/____/____ Initialled: _____

Warfarin History

Date warfarin therapy commenced: ____/____/____

Target range (≥1 unit, in whole units): _____

☐ 2.0 - 3.0 ☐ 2.5 - 3.5 ☐ 3.0 - 4.0

Expected duration for warfarin therapy: indicate below

☐ Long term ☐ Short term

Clinical indication: _____

Heart valve (tick) ☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Tissue ☐ Mechanical ☐ Repair only

INR test dates and warfarin doses

Date	INR	Dose

Medications

Current medications (attach list, medications, health/discharge summary) including herbal medications, vitamins and dietary supplements. ☐ Please tick if attached

Note start/stop dates if recent:

☐ Coumadin (all strengths) ☐ Marevan (all strengths)

☐ Clexane Dose given: _____

☐ Recent antibiotics Name: _____

Start date: ____/____/____ Date ceased: ____/____/____

_____

_____

_____

_____

Medical History

_____

_____

_____

_____