HEALTH CARE PROVIDER TELEPHONE/TELEHEALTH ORDERS **Warfarin Sodium**			
Individual:		Date of Birth:	
Address:		Telephone Number:	
INR Target Range/Goal:		Fax Number:	
Allergies:			

Warfarin Sodium Dosing Instructions: *****Staff receiving order: fill in milligram dosage prescribed for each day of the week in the DOSE BLOCK below. ***Also, 'read back' the order/instructions to the HCP.**			
WEEKDAY	DATE(S)	DOSE	INSTRUCTIONS
Sunday			By mouth once daily in the evening
Monday			By mouth once daily in the evening
Tuesday			By mouth once daily in the evening
Wednesday			By mouth once daily in the evening
Thursday			By mouth once daily in the evening
Friday			By mouth once daily in the evening
Saturday			By mouth once daily in the evening

Warfarin sodium Order **Start Date:**	
Warfarin sodium Order **Stop Date:**	
Next PT/INR Lab **Date/Time:**	
Special Instructions:	

Health Care Provider Name (PRINT):	**Staff Receiving Order:**	**Date:**	**Time:**

POSTED:		VERIFIED:	
DATE:	TIME:	DATE:	TIME:

**HCP, please sign below. DPH MAP Policy requires HCP Confirmation Signature within 72 hours.*

Health Care Provider Signature:		**Date:**	**Time:**

POSTED:		VERIFIED:	
DATE:	TIME:	DATE:	TIME: