OPTIONAL

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| **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:** |  |

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| **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.

|  |  |  |
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| **Health Care Provider Signature:** | **Date:** | **Time:** |
| POSTED: | VERIFIED: |
| DATE: | TIME: | DATE: | TIME: |

Rev\_06-28-23