OPTIONAL

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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: | |

Rev\_06-28-23