HEALTH CARE PROVIDER ORDERS
Warfarin Sodium

Individual:		Address:	
Date of Birth:		Telephone Number:	
Allergies:			
INR Target Range/Goal:			
Medical condition being treated or diagnosis:			

****CURRENT MEDICATION LIST ATTACHED ☐

Warfarin Sodium Dosing Instructions:
*****Please fill in milligram dosage prescribed for each day of the week in the DOSE BLOCK below**:

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/Comments:	
For Questions call:	

Health Care Provider Name (PRINT):	**HCP Signature:**	**Date:**	**Time:**
POSTED:		VERIFIED:	
DATE:	TIME:	DATE:	TIME: