*OPTIONAL*

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

Rev\_06-28-23