*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