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Community Anticoagulation Therapy Clinic
Physician Communication
CAT Clinic Fax 319-558-4049 Phone 310-558-4046

Date: ______________________________ CAT Clinic Nurse; _______________________

Patient Name: _______________________ Patient Telephone: _______________________

Referring Physician:____

INR Date: _______________ INR __________________

Goal: ____________________ Diagnosis: __________________

Last Weekly Dose: _________________________

Patient has had a change in:

____ Medication ____

____ Diet ____

____ Alcohol ____

____ Missed dose ____

____ Extra dose ____

____ Procedure ____

____ Bleeding/Clotting ____

____ Other ____

Patient's INR is out of guideline range please advise:

____

____

____

____________________________________ Date: ________________________
Physician signature

SAMPLE