

Community Anticoagulation Therapy Clinic

Patient Instruction Form

CAT Clinic Fax 319-558-4049

Phone 319-558-4046

Participant Name: \_\_\_\_\_

Referring physician: \_\_\_\_\_

Date: \_\_\_\_\_ INR result \_\_\_\_\_

Diagnosis: \_\_\_\_\_

New weekly warfarin (Coumadin) dose: \_\_\_\_\_

Please take your warfarin (Coumadin) as follows:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Daily Mg							

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Daily Mg							

Special Instructions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Next INR Date: \_\_\_\_\_

CAT Clinic Ref: \_\_\_\_\_

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