

Telephone communication for resident on warfarin

Date: _____ Time: _____

Originator of call: _____ I am calling about warfarin patient <resident name >, one of Dr. <MD name>'s patients at <nursing home>.

The issue I am calling about (*select from the following options*) is:

<p>New INR Result</p> <p>INR result: _____</p>	<p>Change in Condition</p> <p><input type="checkbox"/> fall with potential injury</p> <p><input type="checkbox"/> skin tear with potential complication</p> <p><input type="checkbox"/> fever</p> <p><input type="checkbox"/> ANY bleeding or bruising</p> <p><input type="checkbox"/> other injury:</p> <p><input type="checkbox"/> other medication issue:</p> <p><input type="checkbox"/> abnormal UA test results</p> <p><input type="checkbox"/> abnormal chest Xray results</p> <p><input type="checkbox"/> other, specify: _____</p>	<p>Fall without injury/ Minor skin tear</p> <p><input type="checkbox"/> fall</p> <p><input type="checkbox"/> no injury noted</p> <p><input type="checkbox"/> no bleeding/bruising</p> <p><input type="checkbox"/> skin tear</p> <p><input type="checkbox"/> no redness noted</p> <p><input type="checkbox"/> no drainage</p> <p><input type="checkbox"/> size: apx ____ cm</p> <p>If calling for one of these situations, skip to the Recommended Action section</p>	S ituation
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<p>Last 2 INR test results</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">INR Date</th> <th style="width: 15%;">INR</th> <th style="width: 30%;">Dosing Pattern</th> <th style="width: 15%;">Date from</th> <th style="width: 25%;">Date to</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>Current _____ mg</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>Previous _____ mg</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Indication for warfarin: <input type="checkbox"/> AFIB <input type="checkbox"/> DVT/PE <input type="checkbox"/> MECHANICAL HEART VALVE <input type="checkbox"/> OTHER _____</p> <p>Other important medications the resident is taking (including past 3 days):</p> <p><input type="checkbox"/> antibiotics:</p> <p><input type="checkbox"/> NSAIDs (e.g. ibuprofen, motrin, piroxicam, indocin, meloxicam, etc):</p> <p><input type="checkbox"/> aspirin or Plavix (clopidogrel)</p>	INR Date	INR	Dosing Pattern	Date from	Date to	_____	_____	Current _____ mg	_____	_____	_____	_____	Previous _____ mg	_____	_____	B ackground
INR Date	INR	Dosing Pattern	Date from	Date to												
_____	_____	Current _____ mg	_____	_____												
_____	_____	Previous _____ mg	_____	_____												

<p><input type="checkbox"/> No concerns</p> <p><input type="checkbox"/> I'm uncomfortable about this patient because: <input type="checkbox"/> high INR <input type="checkbox"/> bleeding/bruising <input type="checkbox"/> other</p> <p style="margin-left: 100px;"><input type="checkbox"/> low INR</p>	A ssessment
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<p>Say what you think would be helpful or needs to be done, which might include:</p> <p><input type="checkbox"/> No new orders needed</p> <p>INR/Warfarin Recommendations</p> <p><input type="checkbox"/> Tell me if the warfarin dose should be changed or held</p> <p><input type="checkbox"/> Tell me when to repeat the INR <input type="checkbox"/> In 3 days? <input type="checkbox"/> In 7 days? <input type="checkbox"/> Other?</p> <p>Other Recommendations</p> <p><input type="checkbox"/> Tell me whether to order an antibiotic</p> <p style="margin-left: 20px;"><input type="checkbox"/> If so, should we adjust the warfarin dose?</p> <p style="margin-left: 40px;"><input type="checkbox"/> When should we schedule the next INR test?</p> <p><input type="checkbox"/> Tell me whether to order other tests</p> <p><input type="checkbox"/> Should we send the patient to the emergency department?</p> <p>When do you want us to call again (or under what conditions)?</p>	R ecommended Action
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ENTER ALL ORDERS DIRECTLY ONTO THE PHYSICIAN ORDER SHEET

Based on Nurse Assessment

<p>Response from MD or office</p> <p>Who responded: _____ Date: _____ Time: _____</p>	
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Signature _____ Date _____