

Telephone communication for resident on warfarin

Sample Completed Form

Date: 8/3/07 Time: 3 pm

Originator of call: <u>< your name ></u> I am calling about warfarin patient <resident name >, one of Dr. <MD name>'s patients at <nursing home>.					S ituation
The issue I am calling about (select from the following options) is:					
New INR Result INR result: <u>3.8</u>	Change in Condition <input type="checkbox"/> fall with potential injury <input type="checkbox"/> skin tear with potential complication <input type="checkbox"/> fever <input checked="" type="checkbox"/> ANY bleeding or bruising <input type="checkbox"/> other injury: <input type="checkbox"/> other medication issue: <input type="checkbox"/> abnormal UA test results <input type="checkbox"/> abnormal chest Xray results <input type="checkbox"/> other, specify:		Fall without injury/ Minor skin tear <input type="checkbox"/> fall <input type="checkbox"/> no injury noted <input type="checkbox"/> no bleeding/bruising <input type="checkbox"/> skin tear <input type="checkbox"/> no redness noted <input type="checkbox"/> no drainage <input type="checkbox"/> size: apx ___ cm If calling for one of these situations, skip to the Recommended Action section		
Last 2 INR test results					B ackground
INR Date	INR	Dosing Pattern	Date from	Date to	
<u>7/20/07</u>	<u>3.1</u>	Current <u>6 mg M/W/F & 5 mg T/Th/Sat/Sun</u>	<u>7/13/07</u>	<u>now</u>	
<u>7/13/07</u>	<u>2.2</u>	Previous <u>5 mg per day</u> mg	<u>7/1/07</u>	<u>7/13/07</u>	
Indication for warfarin: <input checked="" type="checkbox"/> AFIB <input type="checkbox"/> DVT/PE <input checked="" type="checkbox"/> MECHANICAL HEART VALVE <input type="checkbox"/> OTHER _____					
Other important medications the resident is taking (including past 3 days): <input type="checkbox"/> antibiotics: <input type="checkbox"/> NSAIDs (e.g. ibuprofen, motrin, piroxicam, indocin, meloxicam, etc): <input checked="" type="checkbox"/> aspirin or Plavix (clopidogrel)					
<input type="checkbox"/> No concerns <input checked="" type="checkbox"/> I'm uncomfortable about this patient because: <input checked="" type="checkbox"/> high INR <input checked="" type="checkbox"/> bleeding/bruising <input type="checkbox"/> other <input type="checkbox"/> low INR					A ssessment
Say what you think would be helpful or needs to be done, which might include: <input type="checkbox"/> No new orders needed					
INR/Warfarin Recommendations <input checked="" type="checkbox"/> Tell me if the warfarin dose should be changed or held <input checked="" 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?					
Other Recommendations <input type="checkbox"/> Tell me whether to order an antibiotic <input type="checkbox"/> If so, should we adjust the warfarin dose? <input type="checkbox"/> When should we schedule the next INR test? <input type="checkbox"/> Tell me whether to order other tests <input type="checkbox"/> Should we send the patient to the emergency department?					R ecommended Action
When do you want us to call again (or under what conditions)?					
Response from MD or office Who responded: _____ Date: _____ Time: _____					

ENTER ALL ORDERS DIRECTLY ONTO THE PHYSICIAN ORDER SHEET

Signature _____ Date _____