

Telephone communication for resident on warfarin

Scenario 2: Mr. LaPelle, Dr. Goldsmith

Date: 8/17/07 Time: 11:00 pm

Originator of call: STATE NAME 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>_____</p>	<p>Change in Condition</p> <p><input checked="" 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 checked="" 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>	<p>S ituation</p>															
<p>Last 2 INR test results</p> <table border="1"> <thead> <tr> <th>INR Date</th> <th>INR</th> <th>Dosing Pattern</th> <th>Date from</th> <th>Date to</th> </tr> </thead> <tbody> <tr> <td><u>8/2/07</u></td> <td><u>2.9</u></td> <td>Current <u>5</u> MWF 7.5 other days ____ mg</td> <td><u>6/8/07</u></td> <td><u>NOW</u></td> </tr> <tr> <td><u>7/6/07</u></td> <td><u>2.6</u></td> <td>Previous <u>5</u> MWF 7.5 other days ____ mg</td> <td><u>6/8/07</u></td> <td><u>NOW</u></td> </tr> </tbody> </table> <p>Indication for warfarin: <input checked="" 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	<u>8/2/07</u>	<u>2.9</u>	Current <u>5</u> MWF 7.5 other days ____ mg	<u>6/8/07</u>	<u>NOW</u>	<u>7/6/07</u>	<u>2.6</u>	Previous <u>5</u> MWF 7.5 other days ____ mg	<u>6/8/07</u>	<u>NOW</u>	<p>B ackground</p>
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<p><input type="checkbox"/> No concerns</p> <p><input checked="" type="checkbox"/> I'm uncomfortable about this patient because: <input type="checkbox"/> high INR <input checked="" type="checkbox"/> bleeding/bruising <input type="checkbox"/> other</p> <p><input type="checkbox"/> low INR</p>			<p>A ssessment</p>															
<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 checked="" type="checkbox"/> Tell me if the warfarin dose should be changed or held</p> <p><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?</p> <p>Other Recommendations</p> <p><input type="checkbox"/> Tell me whether to order an antibiotic</p> <p><input type="checkbox"/> If so, should we adjust the warfarin dose?</p> <p><input type="checkbox"/> When should we schedule the next INR test?</p> <p><input checked="" type="checkbox"/> Tell me whether to order other tests</p> <p><input checked="" 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>			<p>R ecommended Action</p> <p>Based on Nurse Assessment</p>															
<p>Response from MD or office</p> <p>Who responded: _____ Date: _____ Time: _____</p>																		

ENTER ALL ORDERS DIRECTLY ONTO THE PHYSICIAN ORDER SHEET

Signature _____

Date _____