

**Telephone communication for resident on warfarin**

Scenario 4: Mrs. Folz, Dr. Bottos

Date: 8/17/07 Time: 1:00 pm

Originator of call: <u>STATE 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:					
<b>New INR Result</b> INR result: <u>5.1</u>	<b>Change in Condition</b> <input type="checkbox"/> fall with potential injury <input type="checkbox"/> skin tear with potential complication <input type="checkbox"/> fever <input 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: POSSIBLE UTI	<b>Fall without injury/ Minor skin tear</b>  <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 <u>   </u> cm  If calling for one of these situations, skip to the Recommended Action section			
Last 2 INR test results					B ackground
INR Date <u>8/2/07</u>  <u>7/5/07</u>	INR <u>2.6</u>  <u>2.7</u>	Dosing Pattern Current <u>5</u> mg per day <u>   </u> mg Previous <u>5</u> mg per day <u>   </u> mg	Date from <u>6/7/07</u>  <u>6/7/07</u>	Date to <u>NOW</u>  <u>NOW</u>	
Indication for warfarin: <input type="checkbox"/> AFIB <input type="checkbox"/> DVT/PE <input type="checkbox"/> MECHANICAL HEART VALVE <input type="checkbox"/> OTHER _____					A ssessment
Other important medications the resident is taking (including past 3 days): <input checked="" type="checkbox"/> antibiotics: dicloxacillin for a foot infection <input type="checkbox"/> NSAIDs (e.g. ibuprofen, motrin, piroxicam, indocin, meloxicam, etc): <input 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 type="checkbox"/> bleeding/bruising <input type="checkbox"/> other <span style="margin-left: 150px;"><input type="checkbox"/> low INR</span>					R ecommended Action
Say what you think would be helpful or needs to be done, which might include: <input type="checkbox"/> No new orders needed <b>INR/Warfarin Recommendations</b> <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?  <b>Other Recommendations</b> <input type="checkbox"/> Tell me whether to order an antibiotic <span style="margin-left: 20px;"><input type="checkbox"/> If so, should we adjust the warfarin dose?</span> <span style="margin-left: 40px;"><input type="checkbox"/> When should we schedule the next INR test?</span> <input type="checkbox"/> Tell me whether to order other tests  <input type="checkbox"/> Should we send the patient to the emergency department?  When do you want us to call again (or under what conditions)?					
<b>Response from MD or office</b> Who responded: _____ Date: _____ Time: _____					Based on Nurse Assessment

**ENTER ALL ORDERS DIRECTLY ONTO THE PHYSICIAN ORDER SHEET**

Signature \_\_\_\_\_ Date \_\_\_\_\_