

Anticoagulation Clinic

Annual Subtherapeutic INR Letter



PATIENT INFORMATION

Patient Name: _____

Reason for anticoagulation: _____

Date of Birth: _____

WE ARE REQUESTING AN ANNUAL RENEWAL OF SUBTHERAPEUTIC INRS.

LAST YEAR, YOU INDICATED THAT WE SHOULD:

- Continue to boost warfarin, no LMWH for subsequent subtherapeutic INRs
- Start LMWH for subsequent subtherapeutic INR of _____ or less
- Standing order for LMWH for any subtherapeutic INRs of _____ or less

THIS YEAR, WHAT WOULD YOU LIKE US TO DO FOR FUTURE SUBSEQUENT SUBTHERAPEUTIC INRS?

- Continue to boost warfarin, no LMWH for subsequent subtherapeutic INRs
- Start LMWH for subsequent subtherapeutic INR of _____ or less
- Standing order for LMWH for any subtherapeutic INRs of _____ or less

OTHER SPECIAL INSTRUCTIONS:

Signature (no signature stamps please)

Date/Time

Print Name

Phone: (____) _____ Fax: (____) _____

Telephone Order/Read Back: _____

RN Signature: _____

Physician Signature: _____

Date/Time: _____