Bassett Healthcare Network
Point of Care Coagulation Patient Information/Downtime Form

#8991 8/13; 12/13, 1/6/14, 5/15/15,12/4/15,8/19/16,9/8/16,12/16,1/17,4/19,9/23 (f:lab/.pub)

Last Name:_____ First Name: _____ DOB: _____

MRN: _____ DOS: _____

Ordering Provider: _____ CSN:_____

Are you taking Warfarin/Coumadin/Jantoven? (Circle current medication) ☐ Yes ☐ No

Are you on Heparin/LMWH (Enoxaparin/Fondaparinux/Dalteparin) (Circle current medication) ☐ Yes ☐ No

Are you taking a direct acting oral anticoagulant (Eliquis[apixiban], Xarelto[rivaroxaban], Savaysa[edoxaban], or Pradaxa[dabigatran]) (Circle current medication) ☐ Yes ☐ No

Are you taking Argatroban (inpatient only)? ☐ Yes ☐ No

Any Bleeding? ☐ Yes ☐ No Any Bruising? ☐ Yes ☐ No

Bleeding/Bruising Location: _____

Are you on any new medications? ☐ Yes ☐ No

Have you missed any doses in the past week? Day_____ ☐ Yes ☐ No

Please Indicate Daily Medication Dosage

Common strengths are (each tablet is a unique color): Patients generally take warfarin once daily, by mouth. •1 mg (pink tablets) •2 mg (grey/purple tablets) •2.5 mg (green tablets) •3 mg (brown tablets) •4 mg (blue tablets) •5 mg (peach tablets) •6 mg (teal tablets) •7.5 mg (yellow tablets) •10 mg (white tablets).

MON_____ TUE_____ WED_____ THUR_____ FRI_____ SAT_____ SUN_____

It is very common for patients to take larger/smaller warfarin doses on certain days of the week (i.e., 1 tablet on Mondays, Wednesdays and Fridays and 1/2 tablet the remaining days of the week).

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DOWNTIME Lab/Clinic Use Only

Collection: Test Date: _____Test Time:_____ Tech Initials:_____

Results: _____ Seconds _____ INR INTERNAL QC ☐OK

(Inhibitors, such as lupus anticoagulant, may interfere with the prothrombin time and result in INRs that do not reflect the exact degree of anticoagulation.)

INR Reference Ranges: General Population: 0.9-1.1
Routine Oral Anticoagulation: 2.0-3.0
Mechanical Valve: 2.5-3.5
Venous Confirmation for INR results > 6.0 (Confirmatory sample must be drawn for INR > 6.0.)

Critical Value Documentation:

Lab Critical Value: INR > 4.4

Reported to:_____

Date:_____ Time:_____

Reported by:_____
(Tech Name and Title)

Provider Order Signature/: _____Provider #:_____ Date:_____ Time:_____

Provider Review Signature/:_____ Provider #:_____ Date:_____ Time:_____