Follow-up sheet - Anticoagulant therapy

Patient's name _____ **Name of attending physician** _____

Date of birth _____ **Physician's telephone no.** _____

Indication for oral anticoagulant therapy _____ **Pharmacy's telephone no.** _____

Target interval (INR) _____ **Specimen collection site:** _____

Length of treatment _____ _____

Tablet strength _____ **Support person** _____

Pill organizer ☐

Date	INR	Dose taken	Total dose per week	Missed dose	Dietary change	Medication change	Bleeding	Clinical approach Dose warfarin and next INR	Initials
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Comments: