Name:	
DOB:	
MRN:	

ANTICOAGULATION FLOW SHEET

				PATIENT ASSESSMENT:					LAB:			
Provider		**INR Range**		**DATE**	**NOSE Resp.**	**U/L GI**	**GU/ GYN**	**FALL**	**HCT**	**URINE**	**STOOL**	**Pt. Ed. Review**
Indication		**Frequency of Lab**			**Y/N**	**Y/N**	**Y/N**	**Y/N**				
Original Start Date		**Duration of Therapy**			**Y/N**	**Y/N**	**Y/N**	**Y/N**				
HHN		**Beeper**			**Y/N**	**Y/N**	**Y/N**	**Y/N**				
Home Draw		**Beeper**			**Y/N**	**Y/N**	**Y/N**	**Y/N**				
Contact Person/ Phone No.					**Y/N**	**Y/N**	**Y/N**	**Y/N**				

Date Drawn	**Tech Initials**	**Date Rec'd.**	**INR**	**A/C Medication Order**	**Date Pt. Notified**	**Nurse Initial**	**Lab F/U Date**	**Comments/Lab Order**