## WARFARIN DOSING REFERRAL

# *It is Eastern Health policy that all patients on warfarin are safely transitioned for dosing.*

# Warfarin therapy is: □ NEW this admission OR □ CONTINUING

# Warfarin indication: ……………………. Target INR: □ 2.5 (range 2 to 3) □ Other: ( …… to …...)

**Planned duration:** □6 weeks □ 3 months □ 6 months □ 12 months □ Lifelong

 □ To be decided by (referring doctor) ……………□ Other (please state) ……………………………………..

**Is the patient on bridging LMWH? Details** …………………………………………………………………………………………………..

**Doctor/Unit responsible for review:** ……………………………………………………………………………………………………………

# Dear Dosing Service,

Patient Label

NAME………………………………………

UR NUMBER………………………………

DOB…………………………………………

# Re: ……………………………………………………………………………………………

#  (print patient name)

# admitted to ………………......... between …../…../….. to …../…../…..

#  (health service)

# for management of….……………………………………….……………………..

 **(condition)**

# New medication (or send copy of drug chart): …………………………………………………………………………………………………………………….

# …………………………………………………………………………………………………………….Warfarin education □ Yes □ No

# Medication ceased: ……………….…………………………………………………………………………………………………………………………………….

# Most recent INRs and warfarin doses prior to discharge:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | …. /…. / 20…. | …. /…. / 20…. | …. /…. / 20…. | …. /…. / 20…. | …. /…. / 20…. |
| Warfarin Dose |  |  |  |  |  |
| INR |  |  |  |  |  |

# □ Next INR due ….../….../….…

# □ Attach a signed Pathology slip with: ‘INR - on warfarin, Rule 3 Exemption, Lab to dose’\* written on it

# □ Attach a copy of the discharge prescription (provides Warfarin brand and tablet strengths)

**\*this allows multiple INR tests to be performed from the one pathology slip**

# Other relevant information: (e.g. falls risk, compliance, recent Vitamin K, recent interruption to warfarin therapy, liver dysfunction, clinical conditions affecting warfarin metabolism).

# ……………………………………………………………………………………………………………………………………………………………………………………

**Does the patient require bridging LMWH if becomes subtherapeutic? □ Yes □ No**

Name (print): Dr ………….……………………………….. Signed: …………………….……….............. Unit: ………………………………………..

Phone: …………………………….. Pager: ………………………………. Position (e.g. intern): ………………………….. Date: ………………….

**Faxed by:** ………………………………........................................ **Date:** …………………………..**Time:** …………………………………..

Call Haematology Registrar on 9895 3486 and AH Duty Scientist on 9895 3471 to ensure that fax has been received.

### Signed: Dr …………………………. Name (print): ………………………Unit:……………….

### Phone: 9496 - 5000 Pager #: ……………..… Date: ……./……/ 20……

Faxed by:……………………………………………… Date: ……….**/**……**/** **20**…….at…………hrs.

##### To be completed for Eastern Health Pathology patients only (complete for new, continuing and E@H patients)

Eastern Health Haematology registrar desk, Level 4 building B **Phone: 9895 3486 Fax: 9895 3779**

**Office hours: 8:30am – 4:30pm, Monday to Friday.**

\*After-hours also fax 9895 4602 and contact the Haematologist on-call for the laboratory to discuss if the patient will require dosing over a weekend or public holiday (phone Duty Scientist - Box Hill - 9895 3471).