MELBOURNE PATHOLOGY
"We take it personally"

Bar code

New patient ☐

LAB DOSE – INR PATIENTS

Please use this form for warfarin patients converting to lab dosing by Melbourne Pathology on day of discharge/post discharge or as an inpatient/outpatient.

PATIENT IDENTIFICATION/BRADMA LABEL

Patient's first name _____

Patient's surname _____

Address _____

_____

Phone No _____

Date of Birth _____

REPORTING DETAILS

(Please direct the patient to call our Results Department on 9287 7777 if result has not been received by 6pm.)

Does the patient have a Warfarin Care Patient Guide? ☐ Yes ☐ No

Patient

Speaks and reads English? ☐ Yes ☐ No

Speaks other language? (list) _____

Home phone no. _____

Mobile no. _____

Next of kin/English speaking carer

Name _____

Phone no. _____

Relationship to patient _____

GENERAL PRACTITIONER

(Primary medical contact unless otherwise requested)

Name _____

Phone no. _____

Clinic _____

_____

PHARMACY (Complete this section if Dosette or Webster pack managed by local pharmacy)

Name _____

Phone no._____ Fax no. _____

Address _____

_____

DISCHARGE

Hospital of recent discharge and date (if appropriate)

_____

DISCHARGED TO: (Name of Facility)

_____

Phone no. _____ Fax no _____

☐ Rehab Hospital ☐ Nursing Home ☐ Hostel

☐ Independent Living ☐ Home

HOME VISIT ☐ Yes ☐ No

(only on request from referring doctor and only for six weeks post discharge)

MEDICATIONS

(Dosage not required. Attach drug sheet if possible)

_____

_____

_____

Is the patient on clexane? ☐ Yes ☐ No

If yes, date commenced _____

DOSING INFORMATION

Reason for anticoagulation_____

INR Target _____ Duration _____

Warfarin start date _____

Next INR due _____ / _____ / _____ (if arranged)

Dose (and INR) history

(include hospital doses - preferably for the last 10 days)

Date					
Dose					
INR					

Date					
Dose					
INR					

PATIENT AUTHORITY

I hereby authorise Melbourne Pathology to obtain from my medical records all clinical information relevant to my warfarin management.

Completed by: ☐ Patient ☐ Agent*

Name _____

Signature: _____ Date:_____

* If agent, please provide relationship to patient (eg carer, family member, doctor, nurse).

YOUR DETAILS

Name _____

ID no. (PSD)/Designation (non-PSD)

Please fax this request form to 9287 7898.
Place this form in the bag with the accompanying referral and specimen.