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Patient Name: ______________________________ DOB: ___________
Allergies: _________________________ MRN #: __________ Phone #: _________________

Warfarin (Coumadin®) Educational Material and Consent Form

Contract with Patient

- I understand that, as a participant in the anticoagulation outpatient clinic, I am required to have PT/INR lab drawn at scheduled time. If unable to do so, it is my responsibility to call and report this.
- I understand that I will call the anticoagulation program if I do not receive instructions within 48 hours after a blood test. Please Call (706) 322-0528.
- I am able to travel to the lab or arrange for transportation to the lab to have the test drawn.
- I am willing to follow instructions involving compliance with Warfarin dosage and administration, proper diet, and notifying the clinic regarding all drugs that I am taking to include over-the-counter medications.
- I have access to a telephone and can be reached by telephone if necessary.
- I am taking a Warfarin(Coumadin/Jantoven) which must be followed closely in order to protect me from complications. I understand that my noncompliance with any of the above can result in serious health risks and/or termination with the program.

____________________________________ _______________
Patient Signature Date

____________________________________ _______________
Chhokar Clinic Staff Signature Date