Patient Agreement

I am taking warfarin (also known as Coumadin® or Jantoven®), a life-saving medicine that helps prevent blood clots from forming in my bloodstream. Blood clots can be dangerous and even deadly.

___1. I understand that **I must take warfarin correctly** to prevent problems. I understand that I need regular blood tests to measure the effect of warfarin on my blood. I also understand that I must follow all the instructions of my healthcare team for taking this medicine, or I might have the following serious and possibly life-threatening health problems:

   a. Not taking enough warfarin could allow harmful blood clots to form.
   b. Taking too much warfarin can cause me to bleed too easily. I could lose too much blood from a nosebleed or cut, or I could bleed inside my body.

   The clinic nurse has explained to me how to look for these problems, and what to do if they occur.

___2. I understand that the best dose of warfarin has to be determined for each person. The clinic will work closely with me to find the best dose for me. The dose I need may change from time to time. It is important for me to **come to the clinic and keep scheduled appointments** to have my blood tested.

___3. I have been given instructions for taking warfarin safely by the clinic nurse. If I have more questions, **I will read the information given to me, and I can call the nurse at** _____.

___4. I understand that it is my responsibility to follow instructions to:

   ___a. **Take the prescribed dose of warfarin at the right times**.

   ___b. **Keep my diet the same** while I am taking warfarin.

   ___c. Avoid or decrease my use of alcohol while I am taking warfarin.

   ___d. Notify the clinic of all the medicines, vitamins, dietary supplements and herbal remedies I am taking, including those that are not prescribed by a doctor.

   ___e. Notify the clinic of any medical procedures I will have (example: dental work, surgery, etc.)

   ___f. Notify the clinic if I went to the hospital or emergency room.

   ___g. Notify the clinic if I am or plan on becoming pregnant.

   ___h. Notify the clinic if I am having problems remembering to take the medicine or missing doses.

   ___i. **Report any symptoms or problems that I have**, especially bleeding and bruises.

(over)

___5. I will **arrange for transportation** to and from the clinic for appointments and follow-up blood tests.

___6. I understand that I am **expected to come to all my clinic appointments**.

___7. I have access to a telephone and the clinic can reach me at _____, (my phone number) if necessary.

___8. If I am not available at this number, please call _____, at (friend or relative) _____. (phone number)

___9. I will call the clinic: _____ if I cannot make my appointment. (clinic phone number)

I will make another appointment as soon as possible.

_____ _____
Patient Signature Date

_____ _____
Healthcare Provider Signature Date