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PT / INR RESULTS

To: ___________________________________ Fax: ___________________________

From: _________________________________ Phone: ___________________________
Director of Patient Centered Care

Patient: ___________________________________ DOB: __________________

PT / INR Checked On: __________________ PT = __________ INR = __________

Current Dose: ____________________mg (check one) ☐ Coumadin ☐ Warfarin

Physician Comments / Orders:

____

____

____

____

Physician Signature: __________________________________ Date: __________________

Return Fax: ____________________________

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