

Patient details: affix addressograph

Consultant name: ..... Ward: .....

Indication for anticoagulation: .....

Desired therapeutic target (range): .....

Duration of therapy: .....

Treatment started on: ..... / ..... / ..... or prior to admission

**Risk assessment – to be completed for all patients on warfarin (see guidance overleaf)**  
**◆◆ Optimise measures to correct potentially reversible risk factors ◆◆**

Co-morbidities / Risks	Y	N	Co-morbidities / Risks	Y	N	Co-morbidities / Risks	Y	N
Age > 75 years			Liver/renal disease			Labile INR or high target INR		
Uncontrolled hypertension			History of fits / falls / stroke			Poor compliance		
Excessive alcohol consumption			Bleeding lesions or bleeding tendency			Interacting medicines		

**IF ANY risk factor is identified, ensure that consultant responsible for patient is aware and agrees that benefit or warfarin treatment outweighs the risk.**

Name of Doctor completing care plan (print):

Name of Nurse completing care plan (print):

**When (re-)starting warfarin treatment**

UHB staff signature / date	UHB staff signature / date	Patient or carer signature / date
I confirm that the benefits of warfarin outweigh the risks for this patient Doctor		
I confirm this patient understands the risks and benefits of warfarin treatment and is able to comply with monitoring requirements Doctor		
Additional counselling provided (essential for new patient) – Verbal/leaflet Nurse/pharmacist		

**Planning for discharge**

I confirm that this patient is medically fit for discharge

**For Cardiff and Vale University Health Board resident:**

Patient has 2 consecutive INR readings in range and can be left 7 days between dosing or is for slow loading in atrial fibrillation:

- YES - patient referred to GP for monitoring
- NO - patient referred to Acute Response Team (complete ART referral form)

**For non Cardiff and Vale University Health Board Patient**

- Patient referred to local monitoring services

UHB staff signature	UHB staff signature	Date
Name of person accepting patient for INR monitoring: .....	Doctor	
Designation: .....	Doctor	
Next monitoring appointment arranged for: Location: .....	Doctor	
Date: ..... / ..... / ..... Time: .....	Doctor / nurse	
Completed copy of: Warfarin care plan, Warfarin treatment chart, <u>DAL</u> , given to patient to give to monitoring service	Doctor / pharmacist	
Patient has a completed anticoagulant pack	Pharmacist / nurse / doctor	
All INRs and warfarin doses recorded and enclosed (INR on day of discharge and prescribed dose until date of next test have been entered into patient-held record e.g. yellow book)		