Coumadin/ Warfarin Policy

Date:_____

Patient Name:_____

As a patient who is currently taking Coumadin/ Warfarin, I agree to contact **Valley Cardiology** at (847) 888 -2320 every time I have an INR blood test with the following information:

1. Date and time of INR blood test.
2. Place INR was performed.
3. Exact Coumadin/Warfarin dosage I am currently taking.

I understand that failure to comply with the rules regarding my Coumadin/Warfarin dosage and INR blood tests may result in dismissal from the practice.

Patient Signature:_____

Print Name:_____

VMCC Witness:_____