# ANTICOAGULANT THERAPY FLOW SHEET

Diagnosis Requiring Anticoagulant Therapy:_____ Drug Ordered:_____ Therapeutic/Goal Range:_____

| DATE | PT RESULTS | INR RESULTS | PTT RESULTS | CURRENT DOSE | NEW ORDER | NEXT LAB DRAW | NAME OF PHYSICIAN NOTIFIED | DATE/TIME PHYS. NOTIFIED | PHYSICIAN NOTIFIED BY | COMMENTS |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |
| | | | | | ❍ No<br>❍ Yes _____ | | | | | |

| NAME–Last | First | Middle | Attending Physician | Record No. | Room/Bed |
|---|---|---|---|---|---|
| | | | | | |

www.BriggsHealthcare.com
© SAMPLE
(800) 247-2343