Austin Pathology

ANTICOAGULATION SERVICE NEW PATIENT QUESTIONAIRE

PATIENT DETAILS

UR Number (if known)…………………………………… Date of Birth…………………………………………..

☐ Mr ☐ Mrs ☐ Miss

Surname…………………………………………………First Name…………………………………………….

Address………………………………………………………………………………………………………..

Suburb………………………………………………………………………..Post code……………………….

PATIENT CONTACT DETAILS

Preferred Contact Phone Number………………………………………………………………………………

Other Number……………………………………………..Fax Number…………………………………………..

Home Visit ☐ Yes ☐ No

GENERAL PRACTIONER DETAILS

Doctor's Name…………………………………………………………………………………………………

Address……

Suburb……………………………………………………………………….Post code……………………….

Phone Number………………………………………………………………..

Fax Number…………………………………………………………………..

PATIENT CONDITION

Indications for treatment……………………………………………………………………………………..

Target INR…………………………………Duration of Treatment……………………………………………….

Medications……………………………………………………………………………………………………

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Date Warfarin commenced……………………………….Recent Dosing……………………………………..

Clexane dose and frequency……………………………………………………………………………….

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