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| **Please complete the patient details below** |  | **In an emergency obtain advice from Your GP** **or Emergency Dept**For routine Anticoagulation Nurse Enquiries and appointment changes telephone (01582 497537)Monday – Friday 1pm-4pm only. |
| **Name** |  |  |
| **Address** |  |  |
|  |  | **Please Tick the appropriate box below** |
| **Post code** |  |  | Since your last test please advise if you have been in hospital? | Yes | No |
| **Home Tel** |  |  | Are you taking the prescribed anticoagulant dose? | Yes | No |
| **Mobile Tel** |  |  | Have you missed any doses? | Yes | No |
| **Hospital No** |  |  | Have you experienced any unexplained bruising/bleeding? | Yes | No |
| **NHS No** |  |  | Have started any new medications? | Yes | No |
| **DoB** |  |

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| **Anticoagulation Treatment Record** |
| **Date** | **INR** | **Daily Dosage (mg) Comments** | **Signature** |
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