Pt. Name:_____ **Mercy Clinics, Inc.** **INR GOAL:**_____

DOB or #:_____ **COUMADIN FLOWSHEET** **Diagnosis:**_____

If INR is within goal & patient is on same coumadin dosage for 3 visits over at least 6 weeks then continue same Rx and repeat INR in 1 month. otherwise consult physician.

Physician Sig._____

Date	Medication Changes Or Comments	Bruising / Bleeding	Coumadin Dose	INR	Patient Instructions	F/U Protime	Signature

8-21-00

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8-21-00