CPAMS
Community Pharmacist-led Anticoagulation Management Service

PANS
PHARMACY ASSOCIATION OF NOVA SCOTIA

FAX

TO:

Dr.

PHARMACY:

RE:

HCN:

PHARMACIST:

☐ _____

☐ _____

☐ _____

FAX:

FROM FAX:

NO. PAGES:

PHONE:

SUBJECT: INR Test Results and Dose Adjust.

DATE:

To Physician or Nurse Practitioner and Staff: You are receiving this form to facilitate you maintaining an accurate and complete patient record and to avoid duplication of interventions. Informed consent has been provided by the patient.

☐ This notification is for the patient record only. This does not require physician/NP follow-up. We have maintained or adapted the warfarin dose as described below and discussed with the patient. However, if you have concerns or questions about the plan below, please contact the pharmacy at:

_____.

☐ This requires physician or nurse practitioner consultation. Please contact us at the phone number above to discuss further.

The INR Online report with more detail is attached. Key information:

INR Result	
Warfarin Dose Plan (maintained, increased or decreased to X mg)	
Next INR Date	