Clinipath Pathology

Warfarin Care
Enrolment Application

WARFARIN CARE ENROLMENT APPLICATION FOR GPs & SPECIALISTS

Fax to: 08 9262 3653 when completed

Submission of an enrolment application does not guarantee automatic acceptance to our Warfarin Care program.

Please refer to the website for our Eligibility Criteria

Patient Name: _____

DOB: ___/___/___ Sex: ☐ F ☐ M

Address: _____

_____

Home Ph: _____ Mobile: _____

Carer Name: _____

Phone: _____

Referring Doctor (Specialists must include the patient's GP)

Name: _____

Suburb: _____ Ph: _____

General Practitioner

Name: _____

Suburb: _____ Ph: _____

Medical History

_____

_____

Date warfarin therapy commenced: ___/___/___

Hospital: Recent Admission if Applicable

Hospital: _____

Ward: _____

Date of discharge: ___/___/___

Fees - There will be an initial and annual fee. Please refer to the Warfarin Care Program Billing Information or our website for details

Warfarin History:

Date warfarin therapy commenced: ___/___/___

Target range (≥1 unit, in whole units): _____

☐2.0 - 3.0 ☐2.5 - 3.5 ☐3.0 - 4.0

Expected duration for warfarin therapy: indicate below

☐ Long term ☐ Short term

Clinical indication: _____

Heart valve (tick) ☐ Aortic ☐ Mitral ☐ Tricuspid ☐ Tissue ☐ Mechanical ☐ Repair only

INR test dates and warfarin doses

Date	INR	Dose
/ /		
/ /		
/ /		
/ /		

Current medications (or attach a summary) including herbal medications, vitamins and dietary supplements.
Note start/stop date if recent:

_____

_____

_____

_____

Completed by

Name: _____

Date: _____ Initialled: _____