

COUMADIN® (WARFARIN) PATIENT AGREEMENT FORM

1. My doctor or his/her care manager has discussed the benefits and risks of Coumadin treatment with me.
2. I understand the benefits and risks of Coumadin treatment and am willing to take this medication.
3. I have talked with Dr. _____ about my medical condition and understand that Coumadin is the appropriate treatment for my condition at this time.
4. I will not stop Coumadin without being told to do so by my doctor or by his/her representative.
5. I understand that I cannot safely take Coumadin without checking a blood test called an INR (International Normalized Ratio). I may need to have these blood tests done as often as every day or as little as every six weeks depending on my INR results.
6. I will inform the medical professionals managing my Coumadin of any changes in my diet, health, medications, or alcohol intake when discussing my INR results and Coumadin dose. If I cannot follow their instructions, I will let them know.
7. If I am a woman of childbearing age, I understand that I must use the best possible birth control. Coumadin is known to cause birth defects and death in unborn children.
8. I received teaching and written information on Coumadin treatment, if the medication was started by Presbyterian Heart Group.

Patient Signature

Date

Presbyterian Heart Group Signature/Initials

Date

Patient Information
