Anticoagulant Therapy Flow Sheet

Diagnosis Requiring Anticoagulant Therapy: _____ Drug Ordered: _____ Therapeutic/Goal Range: _____

Date	PT Results	INR Results	PTT Results	Current Dose	New Order	Next Lab Draw	Name of Physician Notified	Date/Time Physician Notified	Physician Notified By	Comments

Resident Name: _____ Physician: _____ MR #: _____ Room/Bed: _____

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