

<b>QML – WARFARIN CONTACT RECORD For NEW Patients</b>  (To be completely filled out on first visit only)		<b>Medicare No.</b>	Stick Laboratory Number Bar Code Here	
<p><i>This form needs to be faxed/scanned as an attachment to the original request form. Also get patient to sign the new Warfarin Care Clinic charter, affix a lab number &amp; send as an attachment. If the patient has presented in the late afternoon please advise Warfarin Control on 1300795355</i></p>				
Surname:		Given Names:		
DOB:	Sex: <i>M</i>  <i>F</i>  (Please Circle)	Postal Address:		
CENTRAL REG No:		Temporary Address:		
<p>Contact Numbers (In order of preference). FAX No. if Nursing Home (Please identify the type of number by suffixing – (H)ome, (W)ork, (M)obile, or (F)ax)</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>4) <i>Relative/Neighbour Contact Name &amp; Number For Alternative contact in an emergency</i> <i>Identify relationship</i></p> <p>_____</p>				
Pharmacy Contact if Webster Packs Required:–		PATIENTS WEIGHT (KG) (Estimate)		
Are Domiciliary Nurses Required - Yes or No				
Patient's GP: Name & Address		Specialist: Name & Address		If applicable Copy Dr or Nursing home details (Name & Address)
LAST DOSE (mg):	How long patient been taking warfarin?	When was last INR test?		
Date & Time:				
What is their current dose?		How long have they been taking current dose?*		
*If taking current dose for less than 5 days, please fill table below stating dose and dates.				
Date:	Date:	Date:	Date:	Date:
Dose:	Dose:	Dose:	Dose:	Dose:
Collector Name:		Clinic name & number:		Clinic Phone No: