Name: _____

DOB: _____

Anticoagulant Dosages

Date Started: Date Reviewed:

Provider: Diagnosis:

Special Instructions:

Name of anticoagulant: Target INR: ☐ 2.0-3.0 ☐ 2.5-3.5

Prothrombin Time				Dosage prescribed (mg)							
Date Drawn	Results	Control	INR	Su	Mo	Tu	We	Th	Fr	Sa	Next Test Date