Réseau de santé **Horizon** Health Network

Warfarin Calendar

Patient Name: ____ Month/Year: ____________________

Clinic/health care provider managing warfarin therapy: ____________________ Phone number: __________________

Family Doctor: ____ Phone number: __________________

Community Pharmacy: ______________________________________ Phone number: __________________

Warfarin tablet strength (s): ____________________________________

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	**Notes:** - Missed doses - Changes in my diet or medications - Problems I have experienced - Questions for my doctor or pharmacist
Dose: ___mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	
Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	
Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	
Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	
Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	Dose: __mg	

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