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|-----------------------|----------------------|
| DATE OF INR TEST | (DD / MM / YY) |
| INR READING | <input type="text"/> |
| CURRENT WARFARIN DOSE | <input type="text"/> |

| WARFARIN DOSAGE (Please tick) | | | |
|-------------------------------|---|--------------------------|--------------------------|
| | SAME DOSAGE EVERY DAY | ALTERNATE DOSAGE | 7 DAY DOSAGE |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | DAILY DOSAGE (MG) | DAY (PLEASE CIRCLE) | DATE |
| DAY 1 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 2 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 3 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 4 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 5 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 6 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |
| DAY 7 | <input type="text"/> * <input type="text"/> | M T W T F S S | (DD / MM / YY) |

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|-----------|----------------------|
| NEXT TEST | DATE: (DD / MM / YY) |
| | TIME: (HH / MM) |