

My Responsibilities When Taking Warfarin (Coumadin®) (For Left Ventricular Assist Device (LVAD) Patients)

What are my responsibilities as a patient?

- **Know** your International Normalized Ratio (INR) target range: _____
 - If your INR is above your target range, you are at greater risk of bleeding.
 - If your INR is below your target range, you are at a greater risk of forming blood clots. Blood clots increase your risk of stroke, clotting in your pump, and surgery for a pump exchange.

- **Take** your warfarin (Coumadin®) **exactly** as prescribed.
 - Always be sure you are taking the right dose of warfarin.
 - Warfarin pills come in different colors and doses. Each tablet strength has a specific color. Please make sure you know:
 - the number of tablets to take each day
 - the milligram dose (strength) per tablet
 - the color of your prescribed tablet

- **Get** your INR blood test as instructed by your provider.
 - Blood tests are used to monitor your INR and adjust your warfarin (Coumadin®) dose if you are outside your target range.
 - Testing your blood helps your provider keep you in a safe range.
 - While you have home nursing, your INR blood test will be done in your home.
 - Once you no longer have home nursing, you may go to a local lab of your choice for your INR blood test.

- **Know** the location of the lab you will use to get your blood drawn.
 - Lab name/phone # _____

- **Be available** by phone to keep a good line of communication open with your anticoagulation provider. In the event you have a dangerously low or high INR, your provider will need to make immediate adjustments to your dose.

- **Understand** who your anticoagulation provider will be.
 - Providers with Michigan Medicine’s Anticoagulation Service will manage your care and advise you on how to take warfarin (Coumadin®). They can be reached Monday- Friday 8am to 5pm at (734) 998-6944.
 - Outside of Anticoagulation Service hours, please contact the VAD clinic at (734) 647-7321 option 2.

I have reviewed these responsibilities with my care team. I understand the information and its importance. I agree to follow these instructions under my care team’s guidance.

Patient’s signature: _____

Date: _____

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