calgary health region

# PATIENT RESPONSIBILITIES
## Anticoagulation Management Service

### As a participant in the Calgary Health Region Anticoagulation Management Service I understand that:

- I must be able to travel to the clinic for my appointment(s) and travel to a laboratory for blood tests.
- I must have access to a telephone and be reached by telephone when necessary.
- I am willing to follow instructions in taking my warfarin, proper diet, and will notify the clinic by phone of any changes in drugs I am taking (including over-the-counter drugs) or changes in my health.
- I am taking medicines that must be followed closely in order to help protect me from complications.
- I will call the anticoagulation program if I do not receive instructions within 48 hours after a blood test.
- The anticoagulation clinic will only be involved in managing my anticoagulation therapy, and my other medical conditions will continue to be managed by my family physician.
- Physicians, pharmacists, and nurses managing my anticoagulation may need to access my health records to provide care and to collect information on benefits of the anticoagulation clinic.
- All my personal records for the anticoagulation clinic will be kept confidential.
- Not following the clinic instructions can result in serious health risks and I may be asked to withdraw from the program.

**FOR WOMEN OF CHILDBEARING AGE ONLY:**

- I understand that warfarin is a drug that can cause serious birth defects.
- If I become pregnant while taking warfarin I must notify the anticoagulation clinic immediately as well as my family physician, so a different drug can be started.
- If I plan to become pregnant, I will inform the anticoagulation clinic and my family physician.

**CONSENT FOR METHODS OF COMMUNICATION:**

- I consent to the Calgary Health Region contacting me by the following means (please check √):
  - ☐ Telephone
  - ☐ Telephone messaging system (answering machine or voicemail)
  - ☐ Fax ______________________________
  - ☐ E-mail ____________________________

**I acknowledge that information sent via the above means may not be confidential and/or secure.**

______________________________ ______________________________
Patient Signature Date

______________________________
Patient Name (print)

______________________________ ______________________________
Witness Signature Date

______________________________
Witness Name (print)