

# Your information

---

**Name:**

**Address:**

**Postcode:**

**Home telephone:**

**Mobile telephone:**

**Hospital number:**

**NHS Number:**

--	--	--	--	--	--

**In an emergency obtain advice from:**

**Name of anticoagulant clinic:**

**Name of specialist nurse or clinic contact:**

**Address:**

**Routine telephone number:**

**Emergency telephone number for advice:**

**Name of GP:**

**Address:**

**Postcode:**

**Telephone number:**

**Condition requiring treatment:**

**Name of anticoagulant:**

**Target INR:**

**Intended duration of treatment:**

**Desired therapeutic range:**

**Referring clinician:**

**Clinician managing anticoagulation:**

**Date treatment commenced:**