

## ATTACHMENT II: PATIENT/PARENT-PROVIDER AGREEMENT

### **Patient-Provider Agreement for Anticoagulation Therapy**

Your doctor has recommended anticoagulation therapy for you, which means that you get medicine that helps prevent clots forming in your blood. Warfarin (also called Coumadin®) and low molecular weight heparin (LMWH) are anticoagulation drugs. When used correctly and under close management, these medications help prevent blood clots from forming in your blood stream. Harmful blood clots can result in a stroke or damage to very important organs.

Your doctor has recommended that you take (check all that apply)

- Warfarin**       **Low Molecular Weight Heparin (LMWH)**

These are potentially dangerous medications. When used incorrectly or without regular blood tests, they can cause serious side effects, which could include internal bleeding or a blood clot and can lead to death in some cases.

When used carefully and in the right dose, they can be very safe and helpful medications for you. Every person is different and the dose of medication you will need will change from time to time. For these reasons, it is very important that we see you every few weeks and perform a blood test.

This document is an agreement between \_\_\_\_\_ (Patient Name) \_\_\_\_\_ and the UCDMC Anticoagulation Clinic (Clinic). The purpose of this agreement is to assure you receive the best care and to help you get the most benefit from this medication.

#### **To accomplish this goal, I make the following promises to the Anticoagulation Clinic:**

- I must have a UC Davis primary care physician.
- I agree to provide the Clinic with my phone number and an alternate phone number where I can be contacted.
- If the Clinic calls me, I will return the call.
- I agree to provide the Clinic with the name and phone number of the pharmacy I will use.
- I will take my medication exactly as prescribed by the Clinic.
- I will NOT let my primary care physician or any other health care provider adjust my medication dose unless I discuss the change with the Clinic FIRST. An exception would be during emergency situations, but I understand that I should still notify the Clinic if there is any change to the amount or type of medication I take.

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- I will inform the Clinic if I need to stop taking my medication because I am having a medical procedure or for any other reason.
- I will inform the Clinic about any changes that are made to any drug, herbal/alternative, or over-the-counter medication I am taking, or if I get a new prescription from my doctor.
- If I drink alcohol, I agree to use it in moderation and with consistency and report any changes in the amount I drink to the Clinic.
- Female Patients: I understand anticoagulation therapy during pregnancy can be harmful to developing babies. I am not currently pregnant and will immediately inform the Clinic if I get pregnant. .
- I will contact the Clinic if I have problems such as:
  - Bleeding from the gums or nose that does not stop
  - Red or brown urine
  - Red or black (looks like tar) stools
  - Throwing up blood or anything that looks like “old coffee grounds”
  - Cuts that do not stop bleeding or bruises that grow bigger
  - Very heavy menstrual flow or other vaginal bleeding
  - Severe headaches or feeling unusually lightheaded, dizzy or weak
  - Fall and hit my head
  - Miss more than 2 doses during one week
- I understand that if I get my blood test drawn at a non-UCD lab, I must call the clinic and let them know the lab name and the date I was tested.
- I will call the Clinic if I do not get instructions 48 hours after I have a blood test at UCD or another lab.
- I will seek medical attention if I have any unexplained bleeding.

**I understand that if I do not keep the promises I have made in this agreement, or I do not follow the Clinic’s instructions, the Clinic may stop my anticoagulation therapy or may dismiss me from the Clinic.**

**Clinic Phone Number 916-734-8158**

My signature below confirms that I have had the opportunity to review the terms of the agreement, have had any questions answered to my satisfaction and agree to ALL of the above requirements to receive anticoagulation management at UCDCMC.

Signature of Patient \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient's Representative \_\_\_\_\_

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Print Patient Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Anticoagulation Clinic Pharmacists

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Interpreter (if needed)

Date: \_\_\_\_\_