# Anticoagulant checklist

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| --- | --- |
| Patient NHI/Name | Date |

1. **Is there evidence the patient was informed how to use the medicine?**

Patient Education

Yes □ No □

1. **Is there evidence the patient was informed what to do if they miss a dose?**

Yes □ No □

1. **Is there evidence there was a discussion about possible side effects?**

Yes □ No □

***Symptoms of over-anticoagulation*** *(e.g. excessive bruising, epistaxis, bleeding gums, severe headache, haematuria, haemoptysis, melena, excessive menstrual bleeding, etc)****Symptoms of under-anticoagulation*** *(bluish toes/fingers, chest/severe back pain, blurred vision or symptoms of DVT etc) may signal a life threatening situation.*

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| **Important:** Refer any patient with any presenting symptom(s) to their GP or directly to A&E; especially bleeding or unexplained bruising. |

1. **Is there evidence the patient was informed about interactions with other medicines (prescription, OTC and complementary), supplements, and/or food and alcohol?**

Yes □ No □

1. **Is there evidence the patient was offered written information about their medicine?**

Yes □ No □

Outcome measures

*Questions 6 – 10 are patient questions to assess patient outcomes with the 10 random patients selected.*

1. **Was the patient able to correctly describe (dose/frequency) how to take their medicine?**

Yes □ No □ N/A □

1. **Was the patient able to describe what to do if they missed a dose?**

Yes □ No □ N/A □

1. **Was the patient able to identify a possible side effect of their medicine?**

Yes □ No □ N/A □

1. **Was the patient able to identify who to ask for help with their medicines?**

Yes □ No □ N/A □