OUTPATIENT ANTICOAGULATION FLOWSHEET

Patient's name: _____ Date of birth: _____ / _____ / _____ Medical record #: _____

Indication for anticoagulation (check one): ☐ Atrial fibrillation ☐ Deep vein thrombosis ☐ Pulmonary embolism ☐ Mechanical valve ☐ Cerebrovascular accident ☐ Other

Target International Normalized Ratio (INR)*: ☐ 2.0 to 3.0 ☐ 2.5 to 3.5 ☐ Other: _____

Start date: _____ / _____ / _____ Therapy duration: ☐ 3 months ☐ 6 months ☐ 1 year ☐ Indefinite ☐ Other:

Date	Current dose	INR	Complications	New dose	Next INR	Initials

Dosage Adjustment Algorithms

For target INR of 2.0 to 3.0, no bleeding:*

INR	< 1.5	1.5 to 1.9	2.0 to 3.0	3.1 to 3.9	4.0 to 4.9	≥ 5.0
Adjustment	Increase dose 10 to 20%; consider extra dose	Increase dose 5 to 10%†	No change	Decrease dose 5 to 10%†	Hold for 0 to 1 day then decrease dose 10%	See reverse.
Next INR	4 to 8 days	7 to 14 days	No. of consecutive in-range INRs × 1 wk (max: 4 wks)‡	7 to 14 days	4 to 8 days	See reverse.

For target INR of 2.5 to 3.5, no bleeding:*

INR	< 1.5	1.5 to 2.4	2.5 to 3.5	3.6 to 4.5	4.5 to 6.0	> 6.0
Adjustment	Increase dose 10 to 20%; consider extra dose	Increase dose 5 to 10%§	No change	Decrease dose 5 to 10%; consider holding one dose§	Hold for 1 to 2 days then decrease dose 5 to 15%	See reverse.
Next INR	4 to 8 days	7 to 14 days	No. of consecutive in-range INRs x 1 wk (max: 4 wks)‡	7 to 14 days	2 to 8 days	See reverse.

* For guidance on the duration of anticoagulant therapy, see the ACCP guideline for antithrombotic therapy for VTE disease: https://journal.chestnet.org/article/S0012-3692(15)00335-9/fulltext#sec17.

† If INR is 1.8 to 1.9 or 3.1 to 3.2, consider no change with repeat INR in seven to 14 days.
‡ For example, if a patient has had three consecutive in-range INR values, recheck in 3 weeks.
§ If INR is 2.3 to 2.4 or 3.6 to 3.7, consider no change with repeat INR in seven to 14 days.

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

 Related article: https://www.aafp.org/fpm/2005/0500/p77.html. Updated: November 2018.

Management of Significantly Elevated INR With or Without Bleeding[1]

INR 5.0 to 8.9, no significant bleeding: Omit 1 to 2 doses; reduce dose 10 to 20 percent; monitor frequently. Alternately consider vitamin K1 1 to 2.5 mg orally.

INR ≥ 9.0, no significant bleeding: Hold warfarin therapy; give vitamin K1 5 to 10 mg orally; monitor frequently. Resume at lower dose when INR is therapeutic.

Serious bleeding, any INR: Hold warfarin; give vitamin K1 10 mg slow intravenous (IV) plus fresh plasma or prothrombin complex concentrate, depending on urgency; repeat vitamin K1 every 12 hours as needed.

Life-threatening bleeding, any INR: Hold warfarin; give prothrombin complex concentrate (or recombinant factor VIIa as an alternate) supplemented with vitamin K1 (10 mg slow IV); repeat as needed.

1. Ansell J, Hirsh J, Poller L, Bussey H, Jacobson A, Hylek E. The pharmacology and management of the vitamin K antagonists: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy [published correction appears in Chest 2005;127:415-6]. *Chest* 2004;126(3 suppl):204S-33S.