# Warfarin Care Clinic Charter

## Acceptance Form

**Please sign and return this form to the Warfarin Care Clinic using the enclosed reply paid envelope.**

**By completing and submitting this form, you (and/or your carer) consent to receiving INR results, Warfarin dose instructions and next INR test date information via a Short Message Service (SMS) to a nominated mobile phone.**

- Before you complete this form, please read the Warfarin Care Clinic Charter (including 'SMS Message Warfarin Dosing System' and 'Acknowledgements & Consents' sections). Your signature indicates that you have read and accepted the Acknowledgements and Consents.
- If you have nominated a carer, you authorise this person to receive, acknowledge and action your Warfarin doses and related information on your behalf.

### PATIENT DETAILS:

QML Pathology Reference Number: _____

I, _____ (full name) have read and understood the Warfarin Care Clinic Charter and important Warfarin information, and hereby consent to my enrolment into the QML Pathology Warfarin Care Clinic. By enrolling in the service, I agree to the Warfarin Care Clinic Charter and consent to receiving my results by SMS to the mobile phone number nominated below:

Mobile Phone Number: ☐☐☐☐☐☐☐☐☐☐ Email Address: _____

Patient/Guardian Signature: _____ Date: _____

If signed by the patient's guardian, what is the guardian's relationship to the patient? _____

**Please complete the following details in addition to those of the patient if nominating a carer to receive the SMS on their behalf. SMS notifications can only be sent to patients AND/OR carers that have signed this form.**

### CARER DETAILS:

Surname of Carer: _____ Given Name of Carer: _____

Relationship to Patient: _____

Address of Carer: _____

Mobile Phone Number: ☐☐☐☐☐☐☐☐☐☐ Email Address: _____

As carer for this above mentioned patient, I hereby take responsibility for the receipt, acknowledgement and relevant action of this nominated person's warfarin results.

Carer's Signature: _____ Date: _____

**Please complete the following details in addition to those of the patient if nominating a pharmacy to receive results on their behalf.**

### PHARMACY OPTION:

I do not want to receive my Warfarin dose instructions by SMS. I would like my Warfarin dose instructions faxed to my pharmacy below.

I, _____ (full name) have read and understood the Warfarin Care Clinic Charter and important Warfarin information, and would like my Warfarin dose instructions faxed to my pharmacy:

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____ Pharmacy Fax Number (if known): _____

Signature: _____ Date: _____

**If available in the future, would you be interested in receiving your results via the internet?** **YES** ☐ **NO** ☐