

## INR Self-testing & Self-monitoring: Patient & Anticoagulation Service Provider Agreement Form

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

Date of birth: \_\_\_\_\_

NHS Number: \_\_\_\_\_

Anticoagulation Service Provider (i.e. GP practice or Anticoagulation Clinic):  
\_\_\_\_\_

This is an agreement which should be completed by the patient and their Anticoagulation Service Provider where the decision has been made with the patient, to self-test or self-monitor their INR using an INR machine/coagulometer (such as CoaguChek XS meter) whilst prescribed the anticoagulant warfarin. The agreement form is to ensure that the patient has a clear understanding of what they need to do in relation to self-testing or self-monitoring their INR, but it also sets out the responsibilities of the clinicians (GP practice or Anticoagulation Clinic) involved in this process too.

(N.B. INR - the international normalised ratio (INR) blood test tells you how long it takes for your blood to clot).

**This INR self-testing and self-monitoring agreement form should be used in conjunction with the BNSSG INR self-testing position statement.**

I confirm the following and agree to participate in INR self-testing or INR self-monitoring on the following basis:

- I have had a discussion with my Anticoagulation Service Provider about purchasing the INR machine/coagulometer.
- I have purchased an INR machine/coagulometer as advised by my Anticoagulation Service Provider and this machine has had an initial quality control check with my Anticoagulation Service Provider (i.e. a venous blood test comparison to the INR machine/coagulometer).
- I have been provided with information on the INR machine/coagulometer and have completed training as advised by the Anticoagulation Service Provider (i.e. manufacturers [Roche video](#)) on the use of the INR machine/coagulometer.
- I understand that maintenance of my INR machine/coagulometer is my responsibility.
- I understand that it is my responsibility to arrange for supplies of test strips (that cover the required tests), lancets, and sharps containers on prescription from my GP practice. I understand that over testing and frequent dose changing when self-monitoring my anticoagulant medicine can be counterproductive.
- I understand that it is my responsibility to dispose of sharps and contaminated waste responsibly and in line with local arrangements.

- I will inform my Anticoagulation Service Provider if I move out of area and / or change my GP practice.
- I will keep all clinic appointments as requested and will book and attend a venous INR test to cross check my INR machine/coagulometer at six monthly appointments.
- I (or my carer where relevant) will undergo an annual review to assess my capability / suitability to remain on self-testing or self-monitoring of my INR whilst on warfarin.
- I will only test my INR at the agreed time and date and will accurately inform my Anticoagulation Service Provider of the result and act on the advice given.
- I will record all INR test results and any dose changes in my yellow anticoagulant book. If upon testing, if the INR result is less than 2 or greater than 5.0, I will repeat my INR. If the second result is outside these parameters again, I will contact the Anticoagulation Service Provider and follow the advice given.
- If self-monitoring my INR, I understand that I must send through details of **both** the INR and dosing to the Anticoagulation Service Provider.
- If I experience unexpected bleeding or bruising, I will contact my Anticoagulation Service Provider.
- I will inform the Anticoagulation Service Provider of dates I intend to travel abroad.
- I will contact my Anticoagulation Service Provider if I decide to stop self-monitoring of INR.
- I will inform my Anticoagulation Service Provider of changes to medication, diet, alcohol, herbal remedies, missed anticoagulant doses, changes in lifestyle, dental or surgical procedures, admissions to hospital, interruptions to warfarin treatment, and if I am unwell or have diarrhoea or vomiting.
- I will provide my Anticoagulation Service Provider with my up-to-date contact details.

**I am aware that if I fail to follow this agreement, I will be withdrawn from the INR self-testing or INR self-monitoring process and that my Anticoagulation Service Provider will be informed of my withdrawal.**

**I am also aware that I can be withdrawn from the INR self-testing or INR self-monitoring if it is deemed in my best interest due to persistent unstable INR readings.**

**Patient signature:** \_\_\_\_\_

**Carer signature (if required):** \_\_\_\_\_

**Anticoagulation Service Provider name:**  
\_\_\_\_\_

**Anticoagulation Service Provider signature:**  
\_\_\_\_\_

**Date agreed:** \_\_\_\_\_

Copy of this agreement/contract to be added to the patient's GP practice and /or Anticoagulation Service Provider notes, as well as a copy to be given to the patient.