SUNY Downstate Medical Center
University Hospital of Brooklyn

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Approved By: The Patient and Family Education Committee
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Anticoagulation Medication Alert Card

Name:_____
☐ **Male** ☐ **Female** **Date of Birth:**_____
Address:_____
Phone #:_____
Emergency Contact:_____
Emergency Phone #:_____

Go to the Nearest Emergency Room If You Have Heavy Bleeding.

Doctor's Name: Dr._____
Doctor's Tel#:_____
Pharmacy Name:_____
Pharmacy Tel.#:_____
Allergies:_____
_____

Date	Medication Name	Dose	Frequency