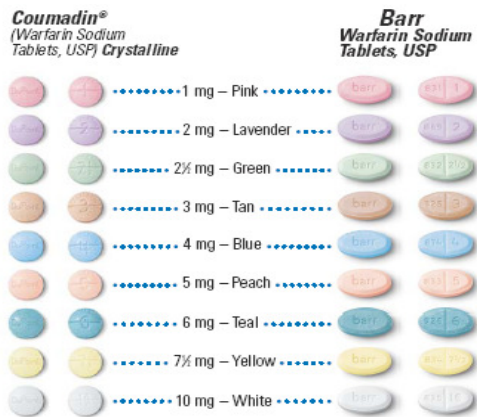


Situational Safety: Colors of Coumadin®

A significant challenge for any medical professional is to determine what medications a patient takes. Many warfarin patients over 65 years old take as many as 9 or more additional prescription medications.¹ These medications can create problems, especially in an emergency situation when a patient needs acute treatment.

Patients must be able to accurately identify their prescription drugs and dosage. Warfarin is a good example of the potential for confusion. There is one brand name and multiple generic forms of the drug. Furthermore, there are nine strengths of warfarin tablets available.



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All warfarin tablets are scored and allow the user to break the tablet in half.

Only brand-name Coumadin® has the name of the medication imprinted on it.

Makers of generic warfarin do not always print the name of the medication on the tablet, making it difficult for patients to identify the tablet once it is removed from the original container.

Most patients know their medications primarily by the color of the tablet, secondly by the quantity taken, and finally by the name of the drug. But, patients should remain 'color-blind' in taking their medicine. Identifying tablets by color has been described as the poorest method of taking medications and communicating information. Patients are encouraged to write down the names of their medications as well as the inscription on the tablet, color, and dose. Patients should also record the intended function of the drug.

Here is a good example: *warfarin: 'Barr', tan, 3 mg (blood thinner)*

A written list of medications makes urgent care significantly easier for physicians in emergency situations. A complete record of a patient's medications can save time, improve the quality of patient care, and sometimes even make the difference between life and death.

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1 Brandeis University Schneider Institute for Health Policy. (2001). Health Improvement Report (Winter ed.) [Brochure]. Irving, TX: AdvancePCS.