APPLICATION FOR INR MACHINE FOR HOME TESTING

PLEASE WRITE CLEARLY

Full name of hospital or centre where child tested	
Name of health professional Address Postcode Telephone number	
Name of child Child's date of birth Name/s of parents/carers Address Postcode Telephone number Email address	
Please give brief reasons why the INR machine is needed	

I confirm that the child named above has a heart disorder and is suitable for this programme, but that the hospital does not comply with recommendations in NICE Diagnostic Guidance [DG14] because

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Signature……Print name……Date……

Please return to INR APPLICATIONS, CHILDREN'S HEART FEDERATION,
Cullen Mill, Braintree Road, Witham, Essex CM8 2DD. Tel: 0300 561 0065 info@chfed.org.uk

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Office use only:

Machine ordered ……..... Letter sent to HCP……..……

Letter sent to parent/s……. Machine received ……..

Training received …….. Invoice paid ……

Invoice No …… Cheque no ……..