

POSTED-LIS

### Coagulation Laboratory Patient Information

To be completed by physician and returned to lab with order for special coagulation.  
(Lupus anticoagulant, Thrombosis Profile, Protein C, Protein S, Antithrombin etc.)

Patient Name \_\_\_\_\_ ID number \_\_\_\_\_

Referring Physician \_\_\_\_\_

#### Coagulation-related MEDICATION, current or past 10 days?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Coumadin                     | <input type="checkbox"/> Plavix (clopidogrel)                         | <input type="checkbox"/> Heparin(Unfractionated) |
| <input type="checkbox"/> Low Molecular Weight Heparin | <input type="checkbox"/> Thrombolytic(t-PA, Urokinase, Streptokinase) |  |
| <input type="checkbox"/> Hirudin(Lepirutin, Reludan)  | <input type="checkbox"/> Vitamin K                                    | <input type="checkbox"/> Argatroban              |

#### Other MEDICATION, Current or past 10 days?

- |                                  |   |
|----------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Oral Contraceptives or Hormone replacement therapy |
| <input type="checkbox"/> NSAIDs  | <input type="checkbox"/> Antibiotics <input type="checkbox"/> OTCs          |

#### Transfusion of Factor Replacement, Past 72 hours? YES No

- If yes, Please specify Factor concentrate \_\_\_\_\_
- |                                |  |  |
|--------------------------------|--|--|
| <input type="checkbox"/> DDAVP | <input type="checkbox"/> Cryoprecipitate | <input type="checkbox"/> Fresh Frozen Plasma |
|--------------------------------|--|--|

#### For DNA Based Testing, has the patient had:

- |  |  |
|--|--|
| RBC Transfusion within the past 3 months | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone marrow transplant                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Transplant                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |

#### Medical History

Patient History	New onset Or Past event	Family History (relationship)	Patient History
<b>Bleeding</b>			<b>Predisposing Condition(s):</b>
<input type="checkbox"/> Menorrhagia			<input type="checkbox"/> Immobility
<input type="checkbox"/> Bleeding after Dental Procedure			<input type="checkbox"/> Trauma
<input type="checkbox"/> Post Operative Bleeding			<input type="checkbox"/> Surgery
<input type="checkbox"/> Petechiae			<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Easy Bruising			<input type="checkbox"/> Oral Contraceptives or HRT
<input type="checkbox"/> Hematoma			<input type="checkbox"/> Tobacco Use
<input type="checkbox"/> Blood in Urine/Stool			<input type="checkbox"/> Malignancy
<input type="checkbox"/> Hemarthrosis			<input type="checkbox"/> Myeloproliferative Disease
<input type="checkbox"/> Other			<input type="checkbox"/> Autoimmune Disease
<b>Thrombotic Events:</b>			<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Deep Vein Thrombosis			<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Pulmonary Emboli			<input type="checkbox"/> Renal Disease
<input type="checkbox"/> Myocardial Infarction			<input type="checkbox"/> Other
<input type="checkbox"/> Stroke			
<input type="checkbox"/> Spontaneous Abortion			
<input type="checkbox"/> Other			