Please Complete and Submit

Coagulation Patient Information

Instructions: To help provide the best possible service, supply the requested information below and send the paperwork with the specimen.

Patient Name *(Last, First, Middle)*	Birth Date *(Month, DD, YYYY)*	Gender ☐ Male ☐ Female

Referring Physician Name *(Last, First)*	Phone	Fax*
Other Contact	Phone	Fax*

**Fax number given must be from a fax machine that complies with applicable HIPAA regulations.*

Clinical Information

Identify the coagulation diagnostic concern or other relevant information

Coagulation-related medication, given currently or in the past 7 days? (check if applies)

☐ Vitamin K
☐ Coumadin (Warfarin)
☐ Direct thrombin inhibitor (Pradaxa [Dabigatran], Acova [Argatroban], Angiomax [Bilvalirudin])
☐ Low-molecular-weight heparins (Lovenox [enoxaparin], Fragmin [Dalteparin], other)
☐ Thrombolytic (t-PA)
☐ Direct Xa inhibitor (Xarelto [rivaroxaban], Eliquis [Apixaban], Savaysa [Edoxaban])
☐ Fondaparinux (Arixta)

Transfusion or Replacement Factor, given within the past 72 hours? ☐ Yes ☐ No

Factor V Leiden Information

Please check test (If neither box is checked, the Factor V Leiden Screen (APCR) will be done)

☐ Factor V Leiden Screen (APCR)
☐ Factor V Leiden Mutation (Genetic) **Please check reason below**

Reason for Factor V Leiden Mutation (check all that apply)

☐ Positive Factor V Leiden Screen (APCR-Activated Protein C Resistance)
☐ Patients on Heparin therapy or oral anticoagulants
☐ Patients with known lupus anticoagulant
☐ Pregnancy
☐ Patients on estrogen replacement therapy
☐ Decision-making regarding oral contraceptive use
☐ Relatives of individuals known to have factor V Leiden
☐ Women with recurrent pregnancy loss
☐ Age <50, any venous thrombosis