

## Coagulation Patient Clinical History Form

Forward this form directly to: HMC Special Coagulation Lab  
325 9th Ave, GWH-47, Box 359743  
Seattle, WA 98104  
Phone 206-744-2621 Fax: 206-744-8654

Patient Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Referring Medical History No: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Physician's phone#: \_\_\_\_\_  
Is patient pregnant:  No  Yes (Due date: \_\_\_\_\_ )  
Pertinent Family History: \_\_\_\_\_  
\_\_\_\_\_

Reason for Testing:  Venous Thrombosis (Date of last thrombosis event: \_\_\_\_\_ )  
 Arterial Thrombosis  
 Bleeding  
 Therapeutic Drug Monitoring  
 Anti-Phospholipid Syndrome  
 Other, please specify: \_\_\_\_\_

Has patient taken any anticoagulants in the past 7 days?  No  Yes (Last dose on \_\_\_\_\_ )  
If yes, check all that apply:

- Coumadin (Warfarin)
- Heparin, unfractionated  Low molecular weight Heparin  Fondaparinux
- Direct thrombin inhibitor [Pradaxa (Dabigatran), Acova (Argatroban), Angiomax (Bivalirudin)]
- Direct Xa inhibitor [Xarelto (rivaroxaban), Eliquis (Apixaban), Savaysa (Edoxaban)]
- Anti-platelet drugs (NSAIDS, Aspirin, Clopidogrel, Prasugrel, Abciximab, etc.)
- Other \_\_\_\_\_

*Completion of the above information will assist us in reflexive testing pathway selection and interpretation of the results.*