

Coagulation Consultation Request Form

Patient Name: _____ Sex: M / F
Last Name First Name MI

Age/DOB: _____ Social Security # _____ Specimen ID #: _____

Referring Facility: _____

Referring Physician: _____ Telephone: _____

Specimen Collection Date/Time: _____

Test(s) Requested: _____

PATIENT CLINICAL INFORMATION: Include Complete Patient History by Physician or Attending Practitioner

REASON FOR REFERRAL:

✓ Check if any of these apply:

- | | |
|--|--|
| <input type="checkbox"/> Abnormal bleeding <small>(Test Mnemonic: COAG-CONS.BLEED)</small> | <input type="checkbox"/> Thrombosis <small>(Test Mnemonic: COAG-CONS.THROM)</small> |
| <input type="checkbox"/> von Willebrand's Disease <small>(Test Mnemonic: COAG-CONS.BLEED)</small> | <input type="checkbox"/> Circulating/Lupus Anticoagulant <small>(Test Mnemonic: COAG-CONS.LUPUS)</small> |
| <input type="checkbox"/> Elevated results for PT and/or APTT <small>(Test Mnemonic: COAG-CONS.PRLNG)</small> | <input type="checkbox"/> Other <small>(Test Mnemonic: COAG-CONS)</small> |

Does the patient have a known factor deficiency? Yes No

If yes, list which factor(s): _____

Give complete patient history as it relates to suspected coagulation abnormality:

MEDICATIONS:

Please list all medications (including over the counter meds and herbal supplements) the patient has received in the last 10 days:

- ✓ Check if the patient has recently received or is currently receiving:
- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Coumadin | <input type="checkbox"/> Unfractionated Heparin | <input type="checkbox"/> Salicylate (aspirin, etc.) |
| <input type="checkbox"/> Vitamin K | <input type="checkbox"/> Low Molecular Weight Heparin | |
- ✓ Check all applicable, if patient has received any type of coagulation factor replacement or transfusion:
- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> Fresh Frozen Plasma | <input type="checkbox"/> Cryoprecipitate | <input type="checkbox"/> DDAVP |
| <input type="checkbox"/> Factor VIII Product | <input type="checkbox"/> Other: _____ | |

COAGULATION TESTING: Please give all results completed in your laboratory.

| | |
|-----------------------|----------------------|
| Platelet Count: _____ | Bleeding Time: _____ |
| Protime: _____ | APTT: _____ |
| Other: _____ | |