

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 Initial) | | Birth Date (Month DD, YYYY) | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Referring Physician Name | Phone | Fax | |
| Other Contact | Phone | Fax | |

Clinical Information

Identify the coagulation diagnostic concern or other relevant information

Coagulation related **Testing Results** from referring laboratory

PT _____ Normal Range _____

APTT _____ Normal Range _____

Platelet Count _____ Hematocrit _____

Other _____

Coagulation-related medication, current or past 7 days? (check if applies)

Coumadin (Warfarin) Vitamin K

Heparin (unfractionated) Low molecular weight heparin/Fondaparinux (Arixta)

Direct thrombin inhibitor Thrombolytic (t-PA)

Direct Xa inhibitor

Transfusion of Factor Replacement, past 72 hours? Yes No

Factor Concentrate - Specify product _____

DDAVP Cryoprecipitate Fresh frozen plasma Humate P

Does the patient have

Known congenital bleeding disorder? Yes No

If yes, which disorder? _____

Known coagulation factor inhibitor? Yes No

If yes, which factor? _____

If type of disorder/inhibitor is unknown we suggest ordering MML test #83097 Prolonged Clot Time Profile

For DNA based testing, has patient had

Transfusion within the past 3 months? Yes No

Bone marrow transplant? Yes No

Liver transplant? Yes No

Von Willebrand Testing Information

Factor VIII Activity Results _____ Normal Range _____

Von Willebrand Factor Activity/Ristocetin Cofactor Activity _____ Normal Range _____

Von Willebrand Factor Antigen _____ Normal Range _____