Coagulation Patient Clinical History Form

To be completed for Thrombosis and Bleeding Workup

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.